Assessment of the process and content of the five year health development plan 2011-15 in Vietnam

By JANS team
Work in progress as of November 8, 2010,
Input for 9 November 2010 workshop

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Background

The Joint Assessment of the National Strategies (JANS) has a general goal of improving planning process and the quality of a health plan, annual health sector plan and provincial health plans, while at the same time, build greater stakeholder confidence in the planning processes of a country.

With the application of Joint Assessment Attributes and criteria (**Annex 1**), a Joint Assessment of the National Strategies (JANS) team, consists of four national and two international experts, conducts an independent assessment of the ongoing development of the five year health sector development plan 2011-15 (thereafter refer to as "**the Plan**"). The assessment covers two main dimensions, the processes of the development of the Plan and the contents of the Plan.

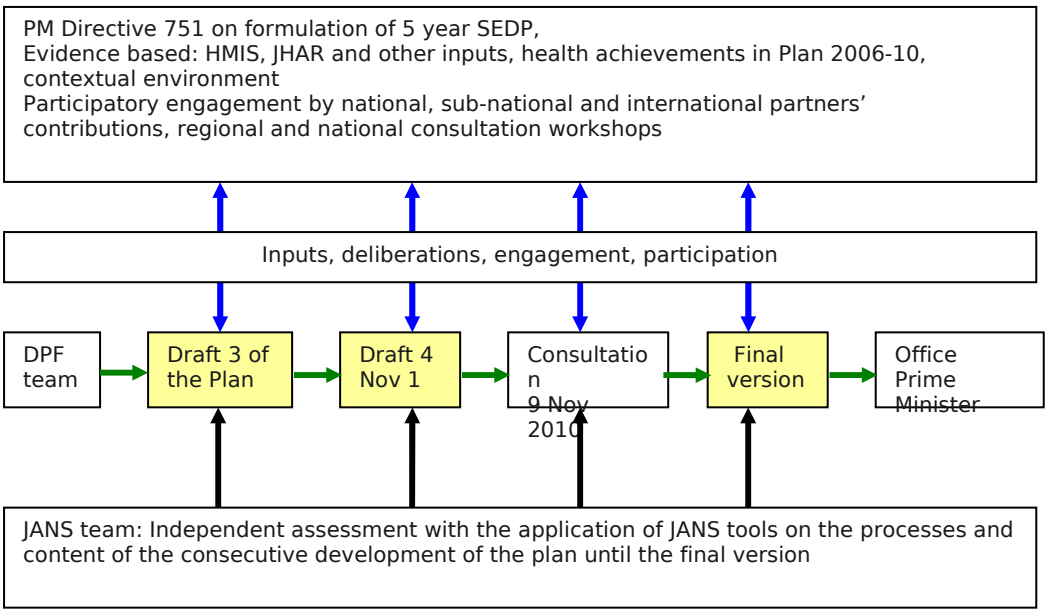
The first assessment by the JANS team based on the Third Draft [1], on the processes and content of the Plan, was fed back unofficially to the Department of Planning and Financing (DPF) of the Ministry of Health [2]. The DPF took serious actions in amendment and come up with Draft 4 by November 1, 2010. In this report, we focus on the assessment of the **fourth draft** of the Plan [3].

It should be noted that in Draft 4, a few amendments were made in track changes to strengthen the text of Draft 3, the majority of the remaining parts were unchanged neither on the content nor the flow of different section of the Plan. Therefore the comment of the content of Draft 4 will also cover that main content of Draft 3.

Draft 4 will be circulated and discussed with multi-stakeholder convened on November 9, 2010, where findings by the JANS team would be presented. Based on inputs and deliberations on 9 November workshop, the DPF would produce the **final version** and submit to the Office of the Prime Minister for approval.

Based on the final version of the Plan, the JANS team will make a final comment to the Plan. See figure 1 on schematic flow of development of the Plan.

Figure 1 Interaction among partners in the construction of the Plan



A few important notes worth clarification:

1. The Plan was prepared according to the mandate provided by the Prime Minister Directive on Formulation of Five-year Socio-economic Development Plan (SEDP) 2011-2015, Ref. No. 751/CT-TTg [4], the Plan therefore is an integral health chapter of the SEDP.
2. Naturally, take into account experiences in the previous plan 2006-2010, the Plan was not drafted in responses to the guidelines provided in JANS tools.
3. Since the inception of the Plan development in early 2011, the preparation processes were not aware of JANS tools and the independent assessment. Therefore the objectives of this exercise are to provide constructive comments and recommends to the process and content of the ongoing work of the Plan in an interactive manner with DPF.
4. Therefore, the independent assessment by the JANS team does not aim to provide pass or fail based on the tool.
5. The Plan contains high level strategic directions which guide to all partners for the next five years: MOH Departments, development partners, National Targeted Programs, Provincial Health Departments and other Ministries and Departments for effective intersectoral actions. It should be noted, in a decentralized systems, it is the Provincial Health Departments who are responsible to develop their own annual plan and budget to be approved by the Provincial People Committee, and that the national five year Plan should guide their direction in a concerted way. The Plan should be brief enough to cover all strategic leverage, and long enough to ensure which partners are responsible on what program, and the linkage of program implementation between MOH and Provincial Health Departments

There are 21 attributes under five main dimensions of assessment namely-

1. Situation Analysis and Programming: it seeks to assess the soundness of analysis/assessment underlying identification of the programming contained in the national strategy.
2. Process: it seeks to assess the soundness and inclusiveness of development and endorsement processes for the national strategy.
3. Finance and auditing: it seeks to assess the soundness of financial and auditing framework and systems.
4. Implementation and management: it seeks to assess the soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy.
5. Results, monitoring and review: soundness of review and evaluation mechanisms and how their results are used.

Objectives

This report provides independent assessment of the process and the content of the Plan: in three versions: Draft 3 produced in October 2010, Draft 4 on November 1, 2010 and Final Version by end November 2010. The assessment will assist DPF on improvement of the process of the development of the Plan as well as the key contents of the Plan.

Methods

Multiple methods were applied; it consists of relevant literature reviews, in-depth interviews of key informants or convening focus group discussion where appropriate (in

terms of time management) among the national, sub-national and international partners, who were closely involved with the process of development of the Plan.

The JANS team, not involved in the process of the development of the Plan, has no conflict of interest in providing independent assessment of the process and content of the Plan.

A short questionnaire was circulated to solicit opinions on the Plan and recommendations how to improve them, to Health Partnership Group-HPG who have keen interests in health sector in Vietnam.

Findings

1. Key informant interviews

In total, there are 25 key informants in-depth interviewed by the JANS team, and one round of focus group discussion among development partners, for which nine participants attended. Key informants were proposed according to their direct hand-on involvement in and contributed to various processes of development of the Plan. We also apply snow-ball recommendations by the key informants after interviews if they wish to refer to any others. Table 1 categorizes key informants into 5 groups.

Table 1 Key informants involved in the process of the development of the Plan Work in progress, Oanh and Phoung pls kindly complete section 1

Category	Number interviewed
1. Five year planning team	8
2. JAHR team members	4
3. MOH Departments	7
4. Other line Ministries, e.g. MOF, MPI	3
5. Provincial Heath Departments	3
Total	25

Information from KI was saturated, when 25 KI were interviewed. The JANS team decided not to conduct further.

2. The construct of the Plan

With the application of six building blocks of health systems [5], the Plan was structured around these six blocks. **Annex 2** describes the structure of the Plan.

After a brief background introduction, Part I provides a critical assessment of the implementation of the health sector development plan (2006-2010), section 1 to 4 on health status and determinants with highlight of three areas namely preventive medicines, treatment and rehabilitation, population, family Planning and reproductive Health and followed by assessment in relation to the six health systems blocks in section 5 to 10 [Human resources for health, Health Information Systems, Pharmaceuticals, vaccines and blood, Medical equipment and technology, Health financing and Governance]. Prior getting to Part I, section 11 assessment on key health indicators which has been implemented by 2010 and section 12 identifies priority issues to be addressed in the Plan

Part II is the main body of the Plan, section 1 starts with assessment of opportunities and challenge, section 2 provides general objectives to achieve for the next five year, which is further clarified by 19 basic health indicators to be achieved by 2015 in section 3.

In order to achieved these health goals, in section 4 ten main tasks are proposed, these include (1) consolidating, developing network of examination and treatment, especially the grass-root health, (2) strengthening preventive medicine, national target program for health, (3) consolidating, developing and improving quality of health examination and treatment, (4) strengthening population and family planning, (5) developing health human resources, (6) developing health information system, (7) renovating health

service operation, financial mechanism, (8) pharmaceuticals and bio-medical products, (9) Medical equipment and (10) strengthening health sector management capacity

Section 5 highlights some investment programs and projects requires further attention such as consolidating health care network at all levels, implementation of national health target programs (after approval by Prime Minister), health human resource development, pharmaceuticals and medical equipment, health financing and strengthening health sector capacity. Section 6 describes monitoring, supervision and evaluation, section 7 assess the risks and difficulties in implementation of the Plan, and final section 8 describes the organization of implementation of the Plan.

3. Assessment of the Plan based on five dimensions and 21 attributes

Annex 3 provides a matrix of full critical assessment by the JANS team on the processes of the development of the Plan and the content of the Draft 3 of the Plan.

4. Viewpoints from development partners in Vietnam

Annex 4 provides a full account of detail comments of the content the Plan and a less extent on the process of Plan development by HPG.

5. Synthesis of key finding by JANS team

5.1 Process of the development of the Plan [Duc and Phoung]

This section captures the process of 5 year plan development from draft 1 to draft 4 to the final version. Figure 2 depicts chronological events and involvement by stakeholders.

It is important to note that the five-year plan was developed under the order of the Prime Minister, Circular No 751 (3/6/09) of PM. The Minister of Health designated this task to the Department of Planning and Financing (DPF), which has been presided over and coordinated the development of the five-year plan.

In January 2010, the DPF established a working team comprising of DPF officials, JAHR team members, European Committee (EC)'s consultants, WHO Development Partner Coordinators. The working team met weekly, first developed a detailed outline of the Plan following guidance from the Minister and contributions from other Departments.

In the following months, DPF conducted a situation analysis and priority setting. To do this, amongst other things, a series of meetings and consultations with other MOH Departments, Health Partner Group (HPG), universities, research institutions, civil societies, and related ministries such as Ministry of Planning and Investment, Ministry of Finance, and Ministry of Labor Invalids and Social Affair were organized. As reported, the process took into account the Joint Assessment Health Reports (JAHR) contributions and inputs of other department within the MOH, National Targeted Programs, and localities. As a result, the first draft was produced in March, 2010.

After launching the first draft, substantial consultative meetings and workshops had been organized to solicit comments of the first draft and recommended inputs for the second version. Firstly, three regional workshops, in Northern, Central and Southern regions, invited representatives from provinces (both Provincial People's committee and Provincial Department of Health) to discuss about the plan. Provincial representatives were also requested to provide and share local information. Secondly, two consultation workshops with the participation of other MOH Departments, NTPs and selected external agencies (MOF, MPI) were held in April 2010 to get inputs and comments for the development of draft 2. Finally, a couple of meetings with leaders of the MOH and HPG were held in June. The second version was produced in June.

It should be noted that less than 20% of Provincial Health Department sent their five year plans, also the quality of comments and recommendations varied.

Having solicited all the inputs from national, sub-national and international development partners, by October 2010, Draft 3 with a significant clarity in the content in particular (a) the analysis of achievement and challenges to-date and (b) what priorities would be addressed in next five years, was produced by the team in DPF. The JANS team observed a "leapfrog" change between the second and third version, a reason for that was the agreement of DPF on employing JANS tools to assess the five-year plan, with the application of WHO six building blocks of health systems strengthening, given that JANS tool was used to assess the third version. In order to produce the third version on time for JANS team; the Plan was developed mainly by a group of technocrats assuming the thorough consultation until Draft 2 was produced. Consequently, draft 3 of the plan was developed in mid-October 2010.

Draft 4 of the plan was developed based on substantive comments and recommendations by HPG and JANS team following guidelines of JANS. The assessment focused on five key components situation analysis, process, finance, implementation, and monitoring and evaluation. HPG provided written comments following structured

questions developed by JANS team. A focus group discussion was convened to discuss the HPG expectation on the Plan and their additional comments. After that a preliminary report, which incorporated comments from JANS team and HPG, was submitted to the DPF. The DPF took into account this report and revised the third draft. On November 1, the fourth version was released. This version has been sent to multi-stakeholders and JANS team to get comments and will be discussed in the consultation workshop on November the 9th for final input.

As key indicators/targets were given significant attention throughout the development of the Plan, the JANS team recommends inserting a section on the process of the development of the list of indicators. The indicators used for the M&E section of the Plan were developed taking into account input, process and outcome/impact components. All indicators were divided into multi-year targets for the whole period to measure progress and performance.

Indicators were developed based on i) the Party's documents, Government's strategies or national plans; ii) annually targeting indicators designated by the National Assembly; iii) the MDG indicators; iv) achievements of the 2006-2010 period; v) orientations for the development of socioeconomics for the 2010-2020 period proposed in the draft document of the National Party Congress XI (Official of DPF); and vi) references from other developing countries with similar socioeconomic conditions.

In order to develop the set of indicators for the Plan, the DPF carried out several steps as follows:

- Conducting an assessment of the achievement of health indicators in the previous Plan (2006-2010);
- Sending proposed indicators and multi-year targets measuring progress to all related Departments and asked for comments;
- Consolidating all comments and feedback and sent the proposed indicators back to the related departments for second comment if they have;
- Organizing a meeting with Department of Labour and Social Affair and Department of Synthesizing and the MPI, and the Committee for Social Affair of the National Assembly,
- Finalizing a set of health indicators (the document No 5597/BYT-KHTC, dated August 20, 2010).

As Draft 3 and 4 were mainly contributed by technocrats in the MOH, the JANS team recommends that it is essential that after the 9 November workshop, the revision of Draft 4 should

- Consult with MOH Department, National Targeted Programs and Provincial Health Departments on its relevance and applicability with provincial situations and their "buy in" during the downstream implementation of the Plan.
- Consult with the private sector and professional organizations who are missed out from the previous processes.

Their comments and recommendations should be taken in the Final version of the Plan, prior submission to the Office of the Prime Minister.

It is clear that all development partners have participated in the process of Plan development. The partners were given opportunities to provide written comments, particular Draft 3, they participated in the working groups and various key consultation meetings. It is observed that through JAHR as well as plan development consultation meetings, broad consultation took place and there was extensive input from a range of stakeholders.

Despite significant engagement by government and development partners stakeholders; private sector and professional organizations have limited involvement and contribution.

Stronger engagement by civil society should be strengthened. There is also concern that involvement by MOH Departments, National Targeted Programs and provincial plans remains limited as well as quality of comments and inputs to the Draft varied. JANS team recommends stronger participation from the whole range of stakeholders so that they buy in the Plan and ensure the plan and strategies were applied and implemented accordingly. There needs a comprehensive representation by Social Committee of the National Assembly, Consumer representatives, professional groups, private sector, education and other relevant sector and grass-roots prevention and examination and treatment.

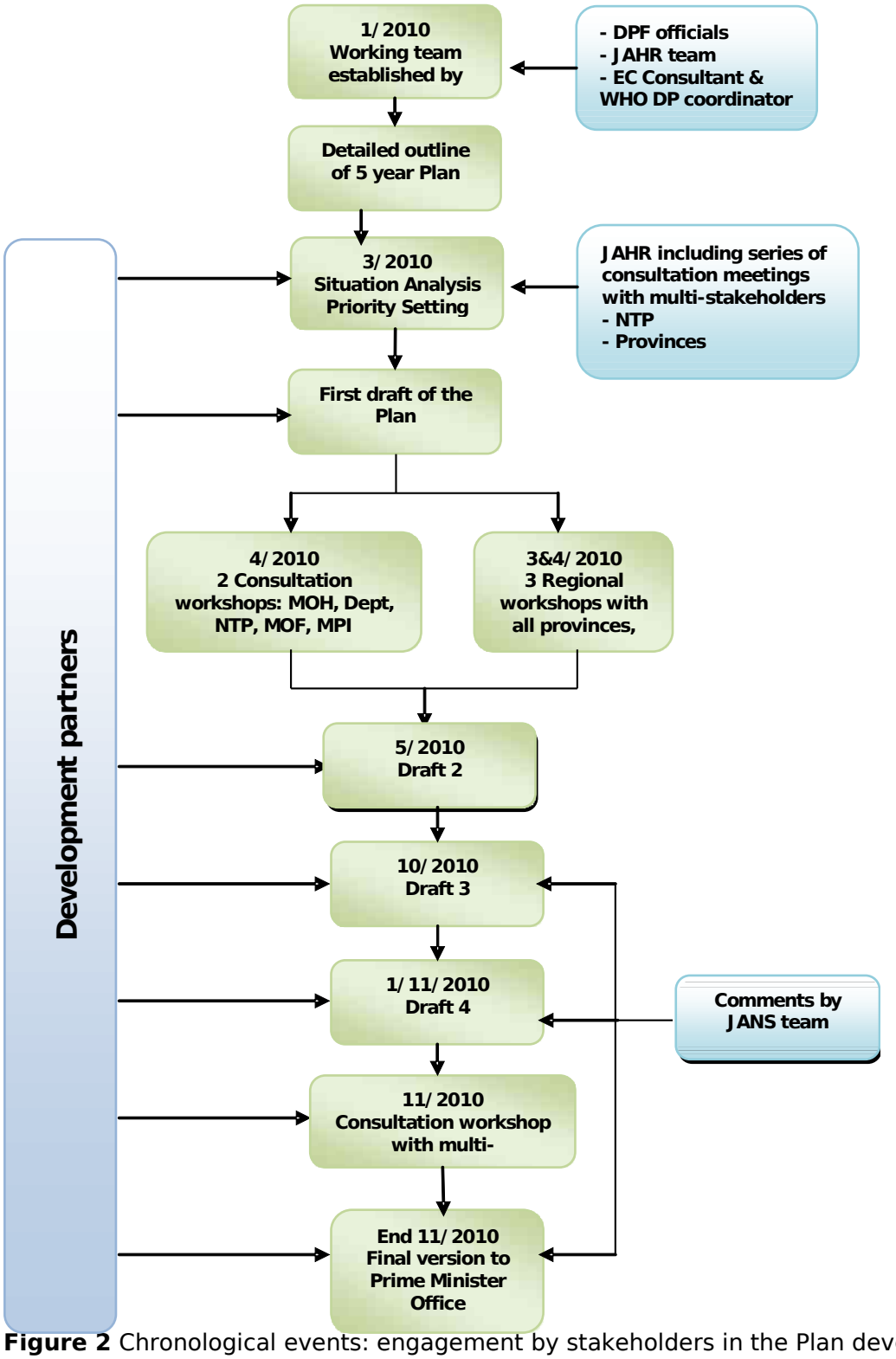


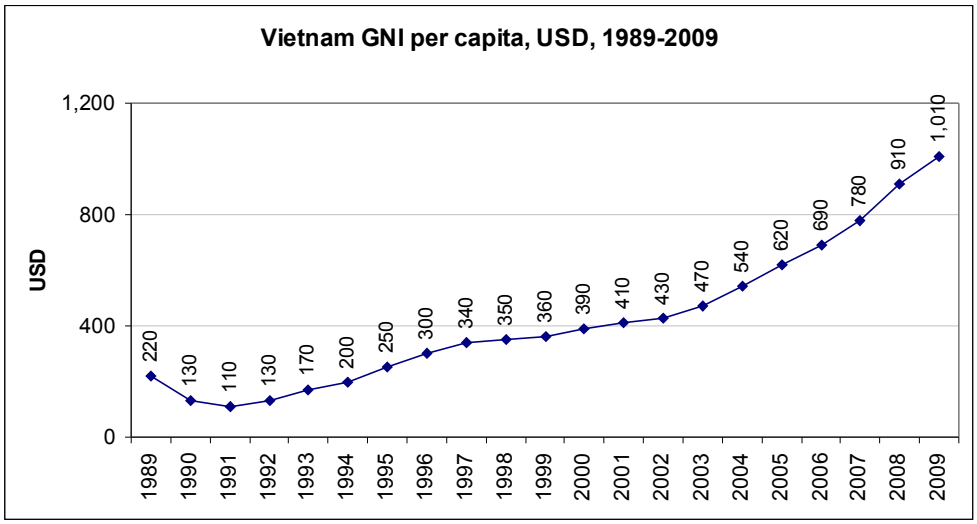
Figure 2 Chronological events: engagement by stakeholders in the Plan development, 2010

5.2 Content of the Plan draft 4 [Phusit and Viroj]

5.2.1 The 2010 contextual environment of the Plan

The economic context, consistent growth, see figure 3, is favourable for health development in the next Plan, although fiscal space, measured by tax as percent GDP was 13% in 2007, Table 2, needs to expand health service infrastructure and increase financial risk protection for the whole population by 2014. Vietnam demonstrates financial commitment in health sector and less reliance on resources from international development partners; being a middle-income country where donor's resource may diminish, it will not affect the health development. The favourable Gini index, 37.8; gap between 10% rich to 10% poor 6.9, gap between 20% rich to 20% poor 4.9] are strong foundation to stride towards improved health equity.

Figure 3 Vietnam GNI per capita 1989-2009



Source: http://data.worldbank.org/indicator/SH.XPD.PCAP/countries

Table 2 Selected ASEAN country profiles

	Cambodia	Indonesia	Lao PDR	Malaysia	Philippines	Thailand	Vietnam
GNI per capita, PPP$ (2008) *	1,820	3,830	2,040	13,740	3,900	5,990	2,700
GDP annual growth, % *							
• 2000	8.8	4.9	5.8	8.9	6.0	4.8	6.8
• 2005	13.3	5.7	7.1	5.3	5.0	4.6	8.4
• 2008	5.2	6.1	7.5	4.6	3.8	2.6	6.1
Fiscal space: government tax as % of GDP *	8.2 (2006)	12.3 (2004)	10.1 (2007)	16.6 (2003)	14.3 (2006)	16.8 (2007)	13.0 (2007)
Poverty incidence: % of population > 1$ a day**	18.5 (2004)	7.5 (2002)	NA	0.7 (2004)	23.0 (2008)	NA	5.0 (2008)
Poverty incidence, % below national poverty line**	34.7 (2004)	20.2 (2009)	32.0 (2002) 27.0 (2008)	8.7 (2004)	32.9 (2006)	21.0 (2000) 8.5 (2007)	18.2 (2006) 13.5 (2008)

Sources: * World Development Indicators database, April 2009, except fiscal space of Vietnam was analysed based on data from the General Statistical Office, Vietnam
** Various official country sources
NA: not available

5.2.2 Cross cutting comments and recommendations

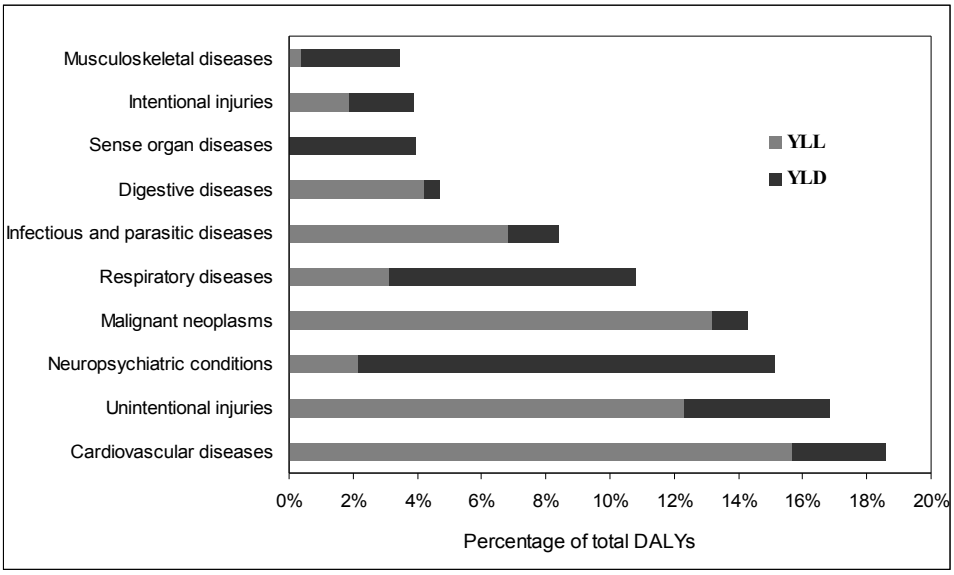
As the Plan is a key reference for the next five years and also key literature for future researches, it would be helpful at the final stage of editing to add sources and date of data where available as a footnote of all figures and tables. In addition, there is a need to assign number and title to all figure and table.

Vietnam is an information rich country, availability of administrative data and household surveys such as Vietnam Living Standard Surveys, DHS, various versions of MICS; these are huge assets for generating evidence for policy decision as well monitoring progress towards health goals. Translating information into policy is not less important than improvement of reliability and validity of administrative dataset, maintaining regularity of household surveys. Strong institutional linkage between MOH and General Statistic Office of Vietnam is indispensable in ensuring household survey questions are relevant to policy interest and uses.

As NCD becomes a major burden in Vietnam, highlighted in a figure under section 1.2, policy analysts cannot rely on hospital statistics--though useful but tend to be a bias sample towards those who access to health services; one needs a population based estimate of burden of diseases. Although a Burden of Disease (BOD) study in Vietnam [6] was launched; further institutionalization of capacity in the assessment of BOD and attributable risks are required for long term monitoring and priority settings. Institutionalization of capacities include the establishment of Civil Registration in Vietnam, improvement in the coverage of mortality registration and accuracy in the cause of deaths and improvement in the epidemiology data (prevalence, disability weight) on non-fatal conditions. This is a worthwhile long term investment--a solid foundation for evidence-based Plan development and health prioritization in the country.

Information on years of life loss (YLL) due to premature mortality, years living with disability for non-fatal diseases and the combination of the two, YLL and YLD forms the total loss in term of disable adjusted life year (DALY). DALY and risk factors contributing to these burdens e.g. unsafe sex, tobacco, alcohol, hypertension and overweight, obesity are foundations, not only for prioritizing health programmes, it contributes to monitoring progresses of policy interventions. For example, a gap between the tobacco consumption contributes to DALY loss and expenditure on tobacco control program points to the need for massive investment to contain tobacco epidemics.

Figure 4 Top-ten DALY loss, Vietnam, 2006



Source National BOD study, VINE project

Figure 4 given the information is valid, is a foundation for prioritization of the Plan. Top three DALY loss are cardiovascular diseases, unintentional injuries and neuro-psychiatric conditions. Note that YLL contributes to a large portion of DALY loss in most of the top ten DALY, except non-fatal conditions such as neuro-psychiatric conditions and sensory organ diseases. The Plan must give priority to risk factors contribute to CVD, road traffic injuries which claims death tolls among prime adults. There is a need to further document the societal and economic loss due to these top ten burden of diseases, which guide to better policy re-orientation. These evidence not only gain political commitment, it guides to program priorities.

Vietnam has consistent economic growth and significant progresses in social development, poverty reduction and health achievement. The country has a strong legal framework which facilitates implementation of health programmes. Not only legal framework, there is clear evidence on strong political commitments towards health of the population. Government effectiveness is a strong foundation for effective implementation of the Plan.

In the context of consistent economic growth in Vietnam, the income elastic of demand for private health care will boost the private health sector growth in particular among the increasing proportion of middle income households and disposal incomes. This poses both opportunities and threats. There are opportunities to bring the private health sector on board in providing quality health services in line with national health goals for which constructive and strategic engagement with this sector is important. Threats if not managed well, it would stimulate internal brain drain of well trained professionals at public resources, from public to private health care. There is a need for a section to provide a critical analysis and how to strengthen the MOH governance and regulatory capacities.

Although in the Plan did not spell out what clinical, public health and social interventions would be applied by various health programs; the JANS teams assumes that all the international guidelines and best practices such as tobacco control, infectious diseases control, non-communicable diseases control highlighted in the Disease Control Priority in Developing Countries [7], Lancet series on child survival [8], Maternal and Child Health interventions [9, 10] where proven cost effective preventive and curative interventions in addressing nine major causes of under five mortalities [diarrhoea, pneumonia, measles, malaria, HIV/AIDS, birth asphyxia, preterm delivery, neonatal tetanus, neonatal sepsis] are described, WHO guidelines on management of drug resistance tuberculosis [11], application of Artemisinin Combination Therapy for Malaria, Chronic NCD [12] would be applied throughout the country.

A recent UK NICE public health guidance 25 [13]: Prevention of cardiovascular disease provides a clear guidance how to prevent CVD, some key policy goals and interventions are useful if it is applicable to the Vietnamese context.

- Reduce population-level consumption of salt.
    - Accelerate the reduction in salt intake among the population. Aim for a maximum intake of 6 g per day per adult by 2015 and 3 g by 2025.
    - Ensure children's salt intake does not exceed age-appropriate guidelines (these guidelines should be based on up-to-date assessments of the available scientific evidence).
- Reduce population-level consumption of saturated fat.
    - Encourage manufacturers, caterers and producers to reduce substantially the amount of saturated fat in all food products. Ensure no manufacturer, caterer or producer is at an unfair advantage as a result.
    - Create the conditions whereby products containing lower levels of saturated fat are sold more cheaply than high saturated fat products. Consider legislation and fiscal levers if necessary.
    - Create favourable conditions for industry and agriculture to produce dairy products for human consumption that are low in saturated fat.
    - Continue to promote semi-skimmed milk for children aged over 2 years. This is in line with the American Heart Association's pediatric dietary strategy [14].
- Ensure all groups in the population are protected from the harmful effects of Industrially-produced trans-fatty acids (IPTFA).
    - Eliminate the use of IPTFA for human consumption.
    - In line with other EU countries, introduce legislation to ensure that IPTFA levels do not exceed 2% in the fats and oils used in food manufacturing and cooking.
    - Direct the bodies responsible for national surveys to measure and report on consumption of IPTFA by different population subgroups – rather than only by mean consumption across the population as a whole.
- Ensure children and young people under 16 are protected from all forms of marketing, advertising and promotions (including product placements) which encourage an unhealthy diet.
    - Develop a comprehensive, agreed set of principles for food and beverage marketing aimed at children and young people. This could be similar to the 'Sydney principles' [15]. They should be based on a child's right to a healthy diet.
    - Extend TV advertising scheduling restrictions on food and drink high in fat, salt or sugar (as determined by the Food Standards Agency's nutrient profile) up to 9pm.
    - Develop equivalent standards, supported by legislation, to restrict the marketing, advertising and promotion of food and drink high in fat, salt or sugar via all non-broadcast media. This includes manufacturers' websites, use of the Internet generally, mobile phones and other new technologies.
    - Ensure restrictions for non-broadcast media on advertising, marketing and promotion of food and drink high in fat, salt or sugar are underpinned by the Food Standards Agency nutrient profiling system.

Intersectoral actions are required; child survival and malnutrition such as the high prevalent stunting are results of poverty and income distribution, job security, food security and resources allocation within households, availability of quality protein

whereby Ministries of Agriculture, Education and other mass organization play a critical role, in addition to MOH. There should be a section highlighted the intersectoral actions.

The experiences of hospital autonomy in financial management tells that if not managed well, for example, the joint venture of medical equipment in public hospitals, such as CT scanner, stimulate unnecessary uses of these high cost technologies, result in inefficiency and inequity for the poor who needs these diagnostics but cannot afford to pay. The supplier induced demand is common in particular in the context of fee for services, and exacerbate by conflict of interest among prescribers and physicians who jointly investment in such technologies in hospitals.

To overcome these problems, and to furnish evidence for policy decision, a new section in Part II of the Plan should be given to the issues and challenges in institutionalization capacities in health systems and policy research, as well as effective mechanism to translate evidence into policy decision, monitoring and evaluation. For example, the favourable outcome of the implementation of Decision 1816 on rotating professional staff from higher level to provide technical support and skill transfers to lower level hospitals with a view to improving quality of care should be carefully assessed to identified its enabling factors and in other challenges (if any), and recommendations to scale up rapidly in a wider scale.

5.2.3 Specific comments and recommendations

Part I Assessment of the implementation of the health sector development plan during 2006-2010

Section 1 Health status and determinants

Vietnam is on track to achieve all health MDG by 2015, extreme poverty eradication has been achieved, MDG4, 5 are well on track, though some changes are needed to achieve MDG6; see Table 3. Despite these progresses, a number of Maternal, Newborn and Child survival indicators needs further attention [16], such as disparity of child mortality across regions and among ethnic minorities, the very poor and those live in remote areas, high prevalence of stunting, the low rate of exclusive breastfeeding and the implementation of the Global Code on marketing breast milk substitute. Most of these problems are well documented in this section.

Table 3 Progress by Goal Current status in accordance with national Government reporting

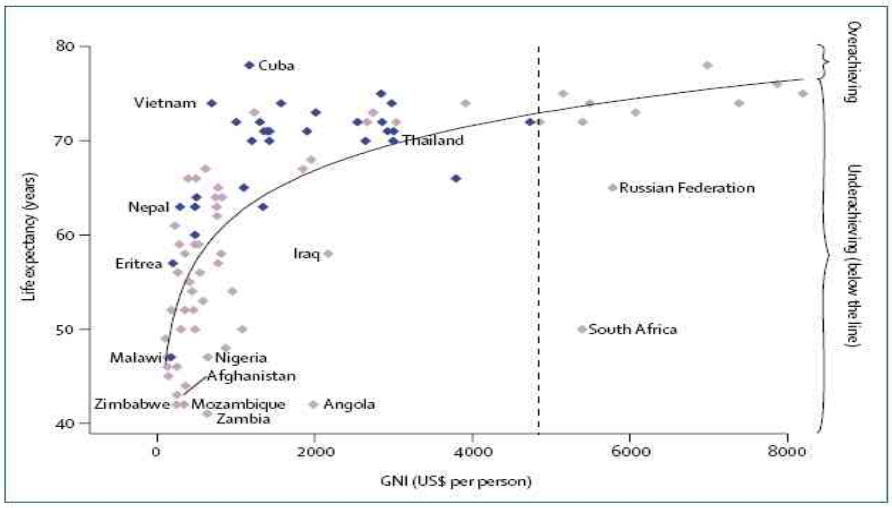
MDG 1	Eradicate extreme poverty and hunger	Achieved
MDG 2	Achieve universal primary education	Very likely to be achieved, on track
MDG 3	Promote gender equality and empower women	Very likely to be achieved, on track
MDG 4	Reduce child mortality	Very likely to be achieved, on track
MDG 5	Improve maternal health	Very likely to be achieved, on track
MDG 6	Combat HIV/AIDS, malaria and other diseases	Possible to achieve if some changes are made
MDG 7	Ensure environmental sustainability	Very likely to be achieved, on track
MDG 8	Develop a global partnership for development	Insufficient information

Source: Tracking the MDG http://www.mdgmonitor.org/factsheets_00.cfm?c=VNM&cd=704

Child mortality performance is confirmed by the fact that, Vietnam is outperformed among low and middle income country group. The annual rate of child mortality reduction between 1990 and 2006 was 7.1% per year [17], and outperforming life expectancy given level of GNI per capita, Figure 5.

In the Plan, these achievements should be maintained through strengthening of health systems in favour of the poor and disadvantage areas (the Northwest and Central Highlands).

Figure 5 Life expectancy in 90 countries with >100,000 annual births, GNI PC< $10,000 in 2006



Source [17]
Note The fitted line represents the regression curve of life expectancy versus log GNI

Table 4 IMR per 1000, eight regions, discrepancy index and annual rate of changes 2005-08

Region	**2005**	**2006**	**2007**	**2008**	**2005**	**2006**	**2007**	**2008**
	Rate per 1000 LB				**Discrepancy index**			
the Red River Delta	11.5	11.0	10.0	11.0	0.7	0.7	0.6	0.7
North East	23.9	24.0	22.0	21.0	1.5	1.5	1.4	1.4
North West	33.9	30.0	29.0	21.0	2.1	1.9	1.8	1.4
North Central Coast	24.9	22.0	20.0	16.0	1.6	1.4	1.3	1.1
South Central Coast	18.2	18.0	17.0	16.0	1.1	1.1	1.1	1.1
The Central Highlands	28.8	28.0	27.0	23.0	1.8	1.8	1.7	1.5
South East	10.6	8.0	10.0	8.0	0.7	0.5	0.6	0.5
the Mekong delta	14.7	11.0	11.0	11.0	0.9	0.7	0.7	0.7
Whole country	16.0	16.0	16.0	15.0	1.0	1.0	1.0	1.0
Annual percent changes		**2005-06**	**2006-07**	**2007-08**				
the Red River Delta		-4%	-9%	10%				
North East		0%	-8%	-5%				
North West		-12%	-3%	-28%				
North Central Coast		-12%	-9%	-20%				
South Central Coast		-1%	-6%	-6%				
The Central Highlands		-3%	-4%	-15%				
South East		-25%	25%	-20%				
the Mekong delta		-25%	0%	0%				
Whole country		0%	0%	-6%				

Table 5 Child malnutrition, eight regions, discrepancy index and annual rate of changes, 2005-08

Region	**2005**	**2006**	**2007**	**2008**	**2005**	**2006**	**2007**	**2008**
	Rate per 1000 LB				**Discrepancy index**			
the Red River Delta	21.3	20.1	19.4	18.1	0.8	0.9	0.9	0.9
North East	28.4	26.2	25.4	24.1	1.1	1.1	1.2	1.2
North West	30.4	28.4	27.1	25.9	1.2	1.2	1.3	1.3
North Central Coast	30.0	24.8	25.0	23.7	1.2	1.1	1.2	1.2
South Central Coast	25.9	23.8	20.5	19.2	1.0	1.0	1.0	1.0
The Central Highlands	34.5	30.6	28.7	27.4	1.4	1.3	1.4	1.4

South East	18.9	19.8	18.4	17.3	0.8	0.8	0.9	0.9
the Mekong delta	23.6	22.9	20.7	19.3	0.9	1.0	1.0	1.0
Whole country	25.2	23.4	21.2	19.9	1.0	1.0	1.0	1.0
Annual percent changes		**2005-06**	**2006-07**	**2007-08**				
the Red River Delta		-6%	-3%	-7%				
North East		-8%	-3%	-5%				
North West		-7%	-5%	-4%				
North Central Coast		-17%	1%	-5%				
South Central Coast		-8%	-14%	-6%				
The Central Highlands		-11%	-6%	-5%				
South East		5%	-7%	-6%				
the Mekong delta		-3%	-10%	-7%				
Whole country		-7%	-9%	-6%				

Discrepancy index of IMR and child malnutrition among eight regions in Table 4 and 5 as well as percent annual change are useful for monitoring progress. Despite poorer child health status in northeast, northwest and central highlands regions, the rate of improvement is impressive for IMR than malnutrition. This pinpoints to difficulties and more efforts in improving nutritional status. To address geographical inequity of health achievement, a special targeted program in the Northwest and Central Highland provinces should be given in the Plan.

On MDG6: TB, Malaria and HIV/AIDS

The MDG tracking reports (see Table 3) that it is possible to achieve if some changes are made on TB, Malaria and HIV/AIDS.

Vietnam is one of 27 countries[1] with high burden of MDR-TB [18]. The incidence of MDR-TB in the new case TB was 2.7% and 19.3% in the old TB cases in 2006 where a total number of 5,900 cases of MDR-TB were estimated. This should be highlighted in this section, as well as the assessment of laboratory capacity and procurement of qualified medicines to address MDR and in particular Extensively Drug Resistant--XDR TB. Vietnam has also reported cases of XDR TB. This section should provide the level of global achievement of at least 70% case detection rate and at least 85% cure rate with the application of DOTS. Adequate level of case detection and successful treatment will prevent secondary multi-drug resistant tuberculosis.

Despite the low level of HIV infection in adults and pregnancies, the performance of PMTCT is not progressing well. The opportunities of high ANC coverage (91%) and high level of birth attended by skilled health personnel, 88% [19], efforts should be given to increase PMTCT coverage. There is no information on the implementation of ART, data can be drawn from the 2010 UNGASS report on HIV/AIDS.

On health determinants

There is a need to clarify what is the factors contributing to imbalance of male and female newborn, stands at 111 boys to 100 girls in 2010; for example, boy preference society, cultural and economic dimensions and availability of termination of pregnancies.

[1] In this report, the 27 high MDR-TB burden countries refer to those Member States estimated by WHO in 2008 to have had at least 4000 MDR-TB cases arising annually and/or at least 10% of newly registered TB cases with MDR-TB. The countries are: Armenia, Azerbaijan, Bangladesh, Belarus, Bulgaria, China, Democratic Republic of the Congo, Estonia, Ethiopia, Georgia, India, Indonesia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Myanmar, Nigeria, Pakistan, Philippines, Republic of Moldova, Russian Federation, South Africa, Tajikistan, Ukraine, Uzbekistan and Viet Nam.

This section should describe effective interventions in reversing this trend, although in the Plan by 2015, it would be stabilised at 113.

On life style determinants

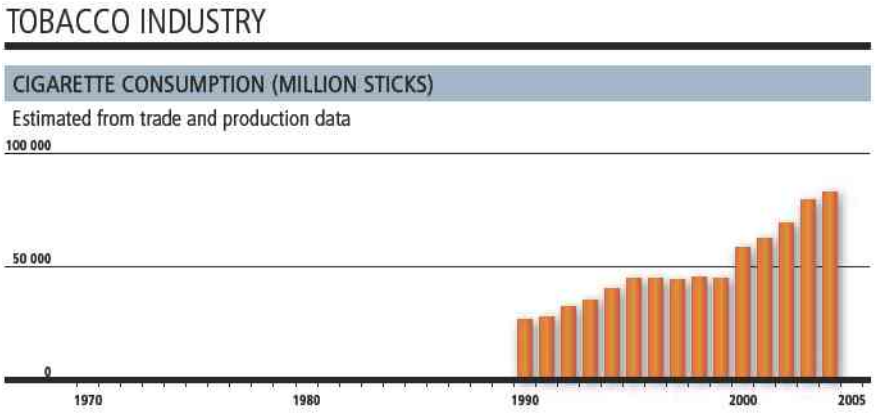
In the Plan, two notably health risks are tobacco and alcohol were highlighted; although the epidemiology of tobacco and alcohol consumption are clearly described, the effectiveness and coverage of policy interventions are not clearly assessed, as a foundation for further implementation of the Plan in 2011-15; for example the adherence and enforcement of smoke free public spaces, protection of non-smokers, taxation in the light of ASEAN Free Trade Agreement that tobacco products will have free flow across the 10 Nations, as import duties are zero. How the Tobacco control program cope with the free trade situation should be described.

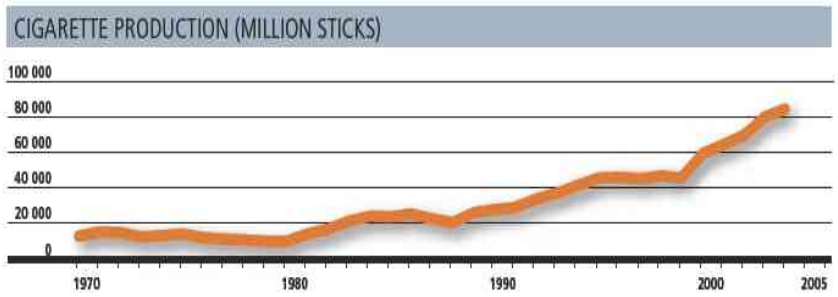
Tobacco is one of the major contributor to chronic NCD and taxation is the most cost effective interventions [20], there are international experiences in introducing "sin tax" and mobilize these resources for active tobacco campaign [21]

> ....."Strong evidence shows that tobacco tax increases, the dissemination of information about health risks from smoking, restrictions on smoking in public places and workplaces, comprehensive bans on advertising and promotion, and increased access to cessation therapies are effective both in reducing tobacco use and in improving the health of populations. Despite this evidence, these policies, especially higher taxes, have been applied aggressively only in a few high-income countries, covering a small proportion of the world's smokers. Limited implementation of effective tobacco control in developing countries is due to political constraints as well as the lack of awareness of the unique effectiveness and cost-effectiveness of these interventions" [20].

The profiles of tobacco epidemic in 2008 were described in Figure 6. Although it is not clearly described in the Plan, the JANS team assumes that the Plan would continue and accelerate implementation of effective tobacco control program in Vietnam, as a signatory to the Framework Convention on Tobacco Control on 17 December 2004 [22]. Effective intervention consists of interrelated tools of MPOWER, namely, Monitor tobacco use and prevention policies, Protect people from tobacco smoke, Offer help to quit tobacco use, Warn about the dangers of tobacco, Enforce bans on tobacco advertising, promotion and sponsorship and Raise taxes on tobacco

Figure 6 Tobacco epidemic profiles, Vietnam, 2008





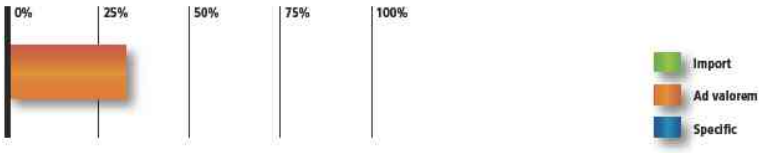
TOBACCO TAXATION AND PRICES

PRICE OF MOST POPULAR BRAND[4]	
In currency reported by country	9 000 VND
USD at official rate	$0.57
International dollars[5]	$2.63

[4] Pack of 20 sticks.
[5] An international dollar has the same purchasing power locally as a US dollar in the United States of America.

TAXES ON THIS BRAND

as a % of retail price



Two excise tobacco tax rates are reported in Appendix II: 41% and 32%. The 41% rate includes the value added tax, in conformity with country practices; the 32% rate depicted in the above graph should be used for international comparison as other countries do not include the value added tax.

AFFORDABILITY OF THIS BRAND	
% of annual per capita income required to buy 100 packs	9%

Source [23]

Section 2 Preventive medicines

The section has clearly described the needs for intersectoral actions, for example animal and human health constituencies, agriculture and live stocks, surveillance in animal and human on zoonotic diseases. In Part II of the Plan, there is a need to highlight a framework of intersectoral collaboration; in particular on strengthening the surveillance systems and laboratory capacity for diagnosis, rapid emergency responses.

Section 3 Examination, treatment and rehabilitation

The bypassing and self-referral of patients from one to another province, from primary care at commune and district level to provincial hospitals results in over-crowding and high travelling cost which prohibit the poor to access. Under the current payment mechanisms by VSS, importing hospitals have incentives to treat those who bypass to generate more to hospital and additional professional income, introducing higher copay by those who bypass is not high enough to prohibit them to travel, the exporting provinces have to pay for services provided by the importing hospitals, leaving limited

resources to improve their service quality and consequently poor quality, untrustworthy services push patients to travel out.

This problems requires comprehensive interventions, one of the entry point is highlighted in the Plan is replacing fee for service by capitation and global budget and case base payment. Other interventions are needed, in particular supply side strengthening, infrastructure with essential equipment for the disadvantage provinces.

Payment reform towards close end methods such as capitation and casemix would effective curb down supplier induced demand and improve efficiency. The JANS team felt that provider payment reform is one of the key leverage towards systems efficiency; though effective referral from lower to high level of care should be closely monitored as close end payment does not encourage gate keeper providers to refer, as they are responsible to pay for services rendered.
There is a need, in medium and long term, to develop national mechanism to responsible for quality improvement, accreditation of healthcare providers, much to be learn from international experiences in introducing hospital accreditation program.

Section 4 Population, family Planning and reproductive Health

This is one of the National Targeted Program, and well resources, due to comprehensive infrastructure, the achievement is very high, contraceptive prevalence rate [percentage of women of reproductive age 15–49, who are using, or whose partners are using, any form of contraception, whether modern or traditional] was very high 79% (1990-2008) [19]. There is a need to provide sub-national rates to guide effective interventions in disadvantaged areas.

It refers to the problem of gender imbalance of newborn 111 boys to 100 girls, but did not analyze the root cause of the problem, which may guide to effective interventions, at least to stabilize to gender gap of newborn. Is it link with practice of abortion once gender was diagnosed by ultrasonogram?

Section 5 Human resources for health

There is a good progress on policy interventions on human resources for health, including increase production capacity, more cadres of skill mix to be trained at bachelor level, also master and doctoral levels, financial incentives introduced though there are rooms for improvement the level of incentive and non-financial incentives, in particular social recognition should be considered. In service continuity training is made mandatory to all medical personnel are major achievements.

The major threat is the growth of private health sector and its impact on the internal migration of well trained personnel from public to private due to higher incentives, there needs a serious capacity building on the regulatory function of the MOH.

There needs a holistic plan between production, employment, rural retention, career advancement and skill mix and responsiveness. The curriculum reform is required, transformative professional education is to ensure appropriate skill mix and responsive to national and local health needs.

One issues in Vietnam is the ratio between doctors and nurses, 1.4 nurses to one doctor whereas in some other countries, there are higher nurses to doctors ratio, e.g. Philippines, 5.5, Indonesia, 6.1 and Thailand 7.7 nurses to one doctor [24]. Task shifting is one of a few promising policy choices. Recent WHO guidelines on increase access to health workers [25] are very useful to plan HRH in Vietnam.

Section 6 Health Information Systems,

Although Vietnam is a data rich country, a Vital Registration Systems has yet to gradually establish [26] to complete accurate record of every births, deaths and causes of deaths. Effective vital registration is a key platform for accurate measurement of BOD, in particular where YLL takes a major share of total DALY loss in most developing countries [27]. The VINE Project should be sustained and gradually institutionalized. Although JAHR significantly provided inputs to the situation analysis of the Plan, it is not a bit unfortunate that the VINE was not "officially released" in time of use and contributes to the situation analysis of the Plan.

> … Accurate mortality statistics, population health assessment, health policy and research are best derived from data in vital registration systems. However, mortality statistics from vital registration systems are not available for several countries including Viet Nam. Capacity-building along with an intersectoral coordination committee involving the Ministries of Justice and Health and the General Statistics Office would improve the vital registration system, especially with regard to procedures for death registration. There appears to be strong political support for sentinel surveillance systems to generate reliable mortality statistics in Viet Nam [26].

Section 7 Pharmaceuticals, vaccines and blood,

There are a few typos in this section. For example, the adverse drug event, not adverse drug resistance, Patent medicines (not patient medicines) is more expensive.

There is no effective regulation through command and control, in encouraging the use of generic medicine and essential drug lists. But strategic purchasing, one of the key functions of healthcare financing, is one of the powerful interventions. Fee for service provider payment does not send a signal towards rationale use of medicine, hospitals have incentives to charge more by using brand drugs [as part of their additional income is from user charges]. In contrast, capitation contract model whereby providers were paid on a fix fee per registered member send a strong signal towards self-containment of cost, encouraging the use of essential drug list and lower cost generic products, in order to keep margin. This is proved by a national experience on affluence use of high cost brand products and cost escalation in one Scheme applying fee for service and higher use of generic medicines and self containment of cost in another Scheme applying capitation contract model [28]. Different provider payment method is one of the factors influencing clinical practice variations.

Further, as described in this section, effective measures to contain the problem of financial incentives offered by pharmaceutical industry in influencing physician's prescribing behaviour in favour of patent medicines are the appropriate provider payment methods such as capitation and DRG which are in the pipeline of development. However, ethical conducts should be supervised by appropriate professional councils. In a dominant fee for service payment in the US healthcare market, the recent US Physician Payments Sunshine Act of 2009 [29], is one of the efforts to make the financial relationship between physicians and industry transparent and publicly known; but yet to prove its effectiveness and compliance.

> … Starting in 2012, drug and medical device companies must report all consulting, speaking and other payments [consulting fees; compensation for services other than consulting; honoraria; gift; entertainment; food; travel; education; research; charitable contribution; royalty or license; current or prospective ownership or investment interest; compensation for serving as faculty or as a speaker for a continuing medical education program; grant; or any other nature of the payment or other transfer of value (as defined by the US Health Secretary)] to doctors and hospitals in excess of $100 annually to the Federal Department of Health and Human Services. These information on payment will be

posted on a public website. This is an important first step toward making transparent the pervasive financial ties between doctors who are studying or promoting specific drugs and medical devices and the companies that manufacture these products.

Due to extensive healthcare infrastructure and government effectiveness, the immunization coverage was sustainable high, more than 95% coverage. There is no doubt that the country could sustain high coverage of routine EPI schedules in the next Plan. However, the introduction of pentavalent vaccines may pose financial constraint when GAVI fund ends; while the country cannot produce the pentavalent combined vaccines.

Section 8 Medical equipment and technology,

It is highlighted in the Plan that there is a need to develop a standard need-base medical equipment requirement by level of care, by region and at primary healthcare level. This is the role of health systems and policy research, pilot testing and some operations research.

Section 9 Health financing

Note with appreciation on the contribution of the National Health Account and other household surveys which provide evidence-based policy decision. Good progress was made in the increase of General Government Expenditure on Health as percent of national budget, from 4.8% in 2002 to 10.2% in 2008; the reduction of out of pocket payment from 80% in 2000 to 52% n 2008 and stride to achieve 30% of state health budget on preventive medicines work.

Due to small benefit package, despite the population coverage of 60.5% by VSS, the expenditure by VSS accounted for 17.6% of Total Health Expenditure in 2008 while out of pocket is high 52%. Expansion of benefit package and higher financial risk protection requires larger fiscal space, as the dominance of funding are taxation for the poor and partial subsidies for the non-poor informal sector.

In a decentralized system, there is a need to mobilize local government interest and funding to health of the population. In the Philippines, Local Government Units often failed to register the poor and meet the required matching fund leaving the poor unprotected. Dialogue is underway on centralizing insurance management to PhilHealth.

With the application of contributory scheme, expansion of insurance coverage to the sheer size of population engaged in informal economy is challenging despite the fact of 50% premium subsidies by the government. Enforcing mandatory contribution among informal sector is hardly successful; for which some countries decided to replace the contributory scheme to general tax financed [30], but such decision should be backup by adequate fiscal space.

At the end of the section, it said.. “The application of copayment mechanism in health insurance for the poor is necessary to contain abuse of health insurance services”. This statement may not be true. Under fee for service mechanisms applied by VSS, the 20% copayment of the medical bills has limited impact in preventing moral hazards created by the patients. Due to asymmetry of information between patients and physicians, the moral hazards created by physicians is a problems that copayment cannot curb. The provider payment method which send appropriate signal towards efficiency and rational use of resources such as capitation and case-base payment is more powerful and effective than reliance on copayment, which creates barriers in access to care by the poor. Policy makers may need to revisit copayment policy.

The stake in achieving universal coverage by 2014 is high, one cannot afford to repeat the mistakes and should draw international lessons in the design, capacity to generate context specific lessons is important, and this is a role of health systems and policy research institutes.

In the Plan, there are three definitions referred to catastrophic health expenditure, for example, Wagstaff [31] which covers indirect costs of seeking healthcare, more than 25% of the non-food consumption expenditure by the households, and more than 40% of non-food consumptions. There is a need to clarify these three different references.

Section 10 Governance

There are a number of policy questions required guidance from evidence generated through health policy and systems researches. For example, it is unclear how to reform the district health centre and integrate public health functions with the curative services. What are the outcomes of implementation of the Decree 43/2005 on financial autonomy? Appropriate policy re-orientation is required based on the outcome of these reviews. In holding providers accountable to the patient needs and be more responsive, there is a need to assess the outcome of the "patient council", prior to nation-wide scaling up this innovation.

In order to respond to the call by the Plan, "Evidence based policy making should be further strengthened", a critical assessment of the national capacity in generating evidence and translate evidence to policy decision is required.

Section 11 Implementation of health indicators

The JANS team notes with satisfaction on achievement of the previous plan 2006-2010, figures in a table in this section shows 15 indicators were all met as planned or better than what is planned by 2010, in particular IMR and U5MR.

Section 12 Priority issues to be addressed

The 10 priorities identified in this section in consistent with the issues and challenged identified in Sections 1 to 10. It was said that these ten priorities are interlinked and should be addressed in a comprehensive manner. Apart from these ten priorities, given resource constraints, special focus would be given to (1) strengthening health care system management capacity, at central and local level; (2) consolidating, stabilizing and developing health delivery system with special attention to the grassroots level, (3) development of health human resource with a long-term vision to 2010 and 2020.

Part II Five year health sector plan 2011-2015

Section 1 Opportunity and challenges

Draft 4 identifies key opportunities and challenges of the Vietnam health system in a clear and comprehensive manner. The five areas of opportunities stated in this section provide clear picture of the enabling environment and context in advancing the Vietnam health system. Also, the draft plan identifies key challenges of the Vietnam health system which are: 1) growing demand for health care of the population in terms of quantity and quality of care; 2) low quality and poor responsiveness of the public health sector; 3) equity and efficiency achievements of the Vietnam health care system in the

midst of market economy and impacts from different health policies; 4) the balanced development between grass-root primary health care level and high cost high technology services in responses to increased demands of these care. JANS team notes that these challenges are drawn from assessment in the Part 1 of this draft plan.

It is noteworthy that apart from these four groups of key challenges, the growth of the private sector without sufficient and appropriate government regulatory mechanism well in place is a key challenge for the Vietnam health system in the next five years. Lessons can be drawn from other countries experiences booming economy and private sector out of control [32].

From the audience's perspective, it would be useful if data related to all key challenges identified in Part I was compiled in this section for quick references; for example, the incidence or prevalence of key non-communicable disease e.g. hypertension, diabetes, cancer, cardiovascular disease, mental disorders, road traffic injuries. In addition, it is unclear on the current proportion of resource to grass-root and primary health care level versus tertiary care hospital.

Section 2 Objectives

The general objectives may be renamed as 'Policy Goals' of the Plan. The general objective (or policy goals) of the Plan is comprehensive, addressing key challenges of the Vietnam health system in the next five years. However, improving quality and safety and responsiveness of the Vietnam health care system is another key dimension that should be added into the goal of this five-year plan. Data from the assessment show some degree of problem and concerns on these issues.

Capturing the contents in the general objectives, it may be reworded along this line.

> The policy goals for the next five years (2011-2015) are
>
> To reduce preventable child and adult mortalities and morbidities, increase longevity and quality of life of population, through cost-effective clinical and ystem that is equitable, quality, ry economy, and other necessary ext of industrialization, es.

The sev es of Part I sections 4.1 to 4.10, while 4 it is a cross cutting. All seven specific did not address the non-health sector

To achi amew NS team, figure 7

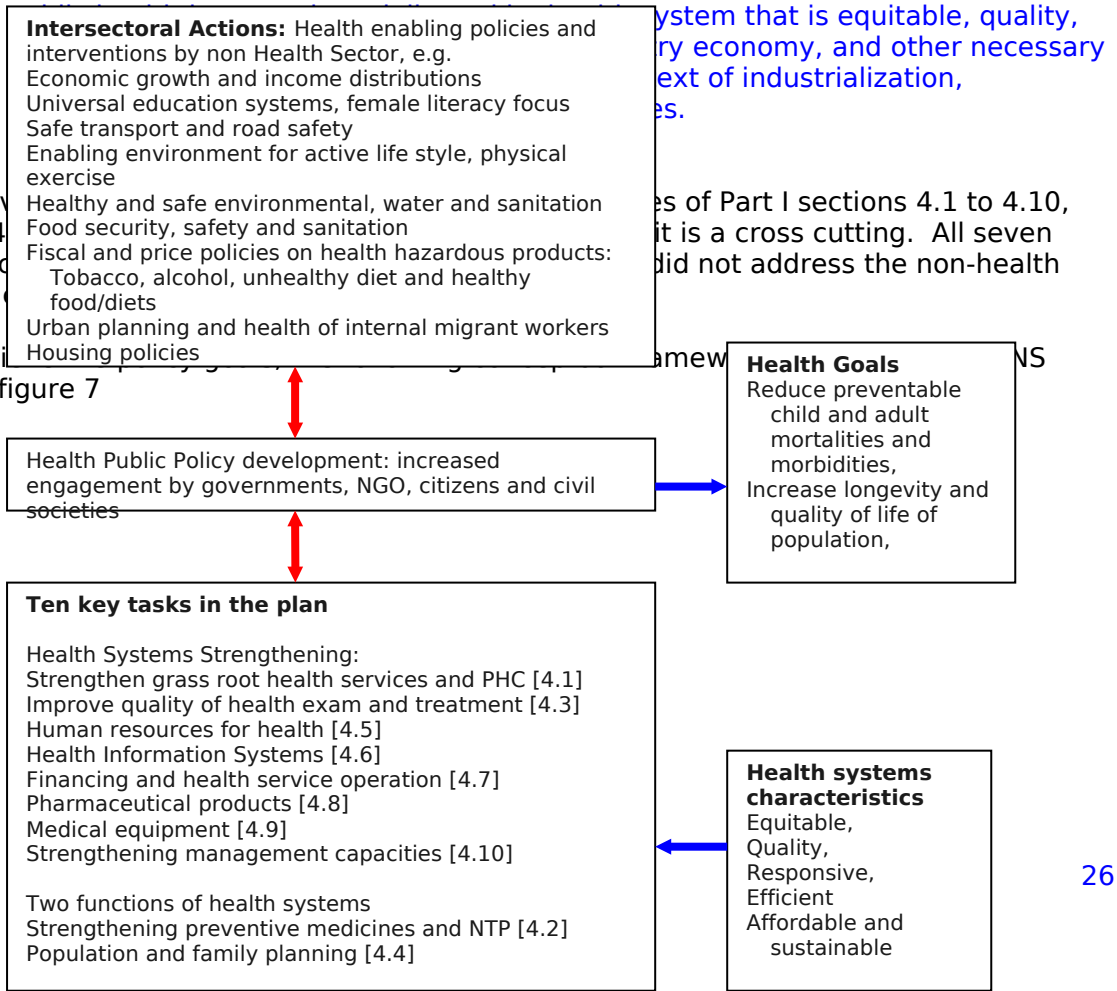


Figure 7 Conceptual framework: contribution of health and non-health sector to health of population

From the analysis of the 7 specific objectives and ten key tasks in The Plan, JANS team appreciates that health systems strengthening components were adequately addressed.

However, the key missing component from the Plan is the health enabling policies and interventions by other non-Health Sector, for example, the income distributions and poverty reduction determine economic well being among the poor and disadvantage groups, female literacy ensure child survival, safe transport and road safety will safe tremendous number of death tolls among prime adult and treatment needs for rehabilitee and disability. Enabling environment for active life style, physical exercise will prevent the over-weight and obesity epidemic associated with economic growth and well being, like other middle income countries. Healthy and safe environmental, water and sanitation will prevent a large number of morbidity. Food security, safety and sanitation will improve the nutritional status while fiscal and price policies on health hazardous products, tobacco, alcohol, unhealthy diet are effective tools [Jha et al DCP2].

It should be noted that female literacy plays significant role in child survival, on average each one-year increment in mother's education corresponds with a 7-9% decline in under five mortality and that education exercises a stronger Influence in early and later childhood than in infancy period [33].

It is therefore recommended that a new section is given to description, discussion the current situation of intersectoral actions, and propose, the next five years, how the health sector, in particular MOH works with other non-health sector and constituencies which contribute to health of the population.

Section 3 Basic health indicators

Some basic health indicators and targets seem to be inconsistent with the data stated in other previous sections. For example, indicator no. 9 on the estimated percentage of villages with active VHW and no. 10 commune with doctors in 2010 differ from table of health indicators in page 20. In addition, it is questionable about targets of indicator no.5 – sex ratio at birth which aims to slightly increase the sex ratio at birth between boys and girls from 111 in 2010 to 113 in 2015. It is unclear why there is neither intention nor strategy to reduce this high discrepancy of sex ratio at birth between boys and girls in the next five years.

In addition, there are duplication and dissimilarity between basic health indicators for monitoring specific objectives (goals) and indicators for supervision in Annex 1. Some basic health indicators for monitoring specific objectives and health sector development, for example, life expectancy at birth, IMR, U5MR, and MMR, are available in supervision indicators of the five-year health sector plan presented in Annex 1. However, there are 46 supervision indicators, but 19 indicators for monitoring, more importantly, benchmark of some indicators are different between these two groups of indicators. It is questionable that which organization will use monitoring health indicators and which one will use supervision indicators.

Section 4 ten key tasks

4.1 Consolidating, developing network of examination and treatment, especially the grass-root health,

This task aims to strengthening grass-root health network and address the current situation of inequitable access to basic health care in rural and remote areas of Vietnam, particularly the North West and the Central Highlands. It also aims to support most communes to achieve the national benchmark of commune in 2015. However, it is

unclear about the strategies to achieve such goals, and financial resource as well as human resource gaps. Data on current situation of communes in eight regions and by province would be useful as benchmark and planning for resource allocation to fill such gaps.

4.2 Strengthening preventive medicine, national target program for health,

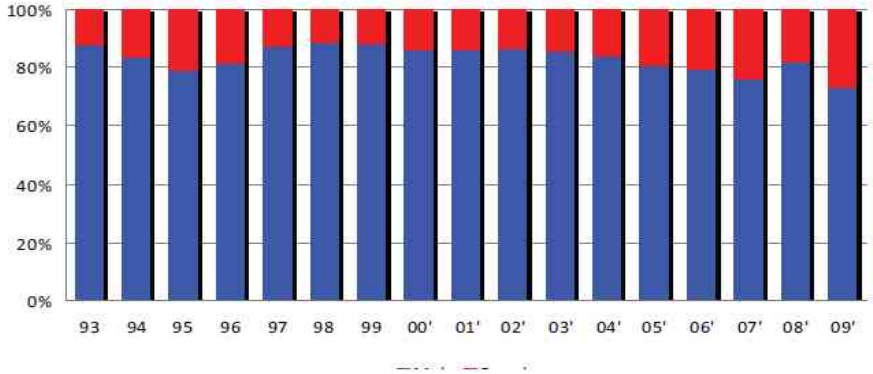
This task is a high concern of this five-year plan because there are a lot of details about strategies and goals in many dimensions of the preventive medicine. However, in the 2nd paragraph of the national program for prevention on social and dangerous epidemic diseases, data on some communicable and non-communicable diseases are unavailable and didn't present in the previous section. For example, data on incidence and prevalence of leprosy and cancer which are emphasized as the national health priorities should be presented in the assessment section of Part 1.

In addition, it would be useful if details of paragraph 2 in task 4.2 will be categorized into three groups of disease burden as CD, NCD, and injuries. The strategies to address these three groups of disease burden tend to be different from each other. Since NCD is an increasing concern for the Vietnam health system, the Plan should identify key strategies using cost-effective health interventions presented in the Disease Control Priorities in Developing Countries, 2nd edition (DCP2) [34] to address the increasing challenge of NCD.

It is concerned that goals and key strategies for prevention of the National Target Programs for 1) health 2) food safety and hygiene 3) population and family planning, and 4) HIV/AIDS prevention are inadequately incorporated into the Plan. Therefore, key goals and strategies of the national target programs should be emphasized and rewritten, rather than describing name list of the projects.

From the 2010 Vietnam UNGASS report, the HIV epidemic in Viet Nam is still in a concentrated stage, with the highest HIV prevalence found in specific populations – namely injecting drugs users (IDU), female sex workers (FSW) and men who have sex with men (MSM). The majority of PLHIV are under 40, and people aged 20-39 years account for more than 80% of all reported cases and the proportion of PLHIV aged 30-39 is showing signs of increasing. Men accounted for 73.2% of all reported cases in 2009 (Figure 8). Therefore, clear strategies for specific populations are needed together with improvements in coverage of MTCT and ARV.

Figure 8 Distribution of reported HIV cases by gender and by year, 1993-2009



Source: *Report on HIV/AIDS epidemic by quarter 4, 2009. MOH, 2010*

There are some typos, for example, in pargraph3, reproductive health care, not productive health care; and in paragraph 8, plan for emergencies, not immergencies.

4.3 Consolidating, developing and improving quality of health examination and treatment,

This is another key concern in the next five-year of the Vietnam health system because evidence in Part 1 shows problems in quality and responsiveness of health service provision, together with inadequate and mal-distribution of human resources for health, and inequitable health care financing which mainly rely on out-of-pocket health payments (80% in 2000, 65% in 2005, and 52% in 2008). Although many key strategies proposed in task 4.3 are quite clear and being grouped into different dimensions, the strategies tend to be fragmented and lacking of linkage among different areas of quality improvements. In addition, there is no prioritization of all key strategies.

Some strategies also involve and duplicate with other tasks, for example, human resources for health in task 4.5 and renovating health service operation and financial mechanism in task 4.7. It would be easier to understand if some strategies in this task show the linkage with strategies in other related tasks.

It would be more sustainable and substantial in quality improvements if the Plan will establish a monitoring and surveillance mechanism on patient safety and quality assurance of health service provision. This might be an office with full time staff and adequate financial resources for monitoring patient safety and quality of health services. In addition, councils or associations of each profession, for example, Medical or Nurse Council should be strengthened and being in charge of monitoring medical misconduct or malpractice. National treatment guideline and hospital accreditation (HA) are also worth setting up.

4.4 Strengthening population and family planning,

To reduce the annual population growth rate below 1% and maintain fertility rate (population growth rate reduction) at 0.02% per 1000 requires strong policy and political support, clear strategies, and effective measures of reproductive health care to achieve such targets. Since Vietnam has a big proportion of women at the reproductive age which will be a big challenge in high demand for reproductive health care and paediatric care in the next five years.

It is still unclear about he comprehensive and effective measures to reduce imbalance in sex ratio at birth. The draft plan tends to have small intention to reduce this imbalance from 111 in 2010, but allow the imbalance to be 113 in 2015.

4.5 Developing health human resources,

This task provides clear detailed information about the strategies to address the problems of human resources for health in terms of production, quality, redistribution, and retention. However, some effective interventions to improve incentives for those who work in remote areas, for example, hardship allowance, should be considered to be included in the draft plan. In addition, the interaction between public and private sectors including the problems of internal brain drain should be emphasized and policies to mitigate negative impacts from such problems should be clearly stated.

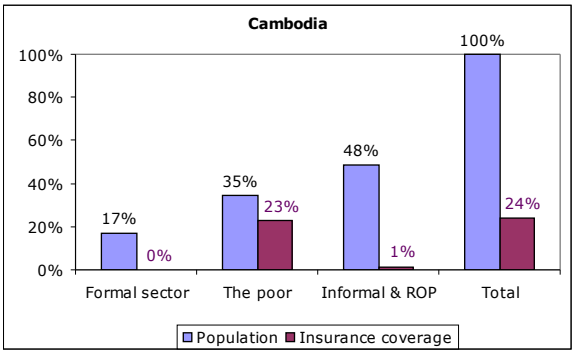
4.6 Developing health information system,

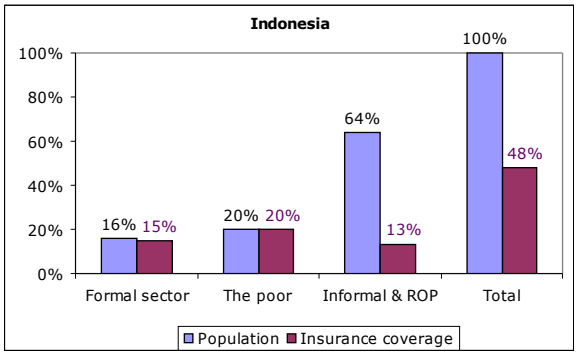
There is intention to develop a national master plan for the health information system (HIS) which includes data from all levels and both public and private sectors. The question on how to enforce the private sector to cooperate with the national HIS, and the issues of coverage, accuracy, and timeliness of HIS, require clear strategies to achieve good and effective HIS.

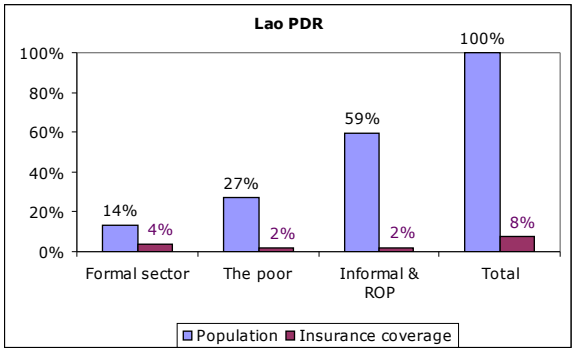
4.7 Renovating health service operation, financial mechanism,
In this task, it is clear that the Vietnam government intends to invest more on the health sector as stated in the National Assembly Resolution 18. However, it is inconsistent between task 4.7 and page 17 on health financing. The former reveals the target to ensure resource allocation at least 30% of the state budget for preventive medicine and primary care, mountainous, remote and isolated areas, while the latter indicates the target to achieve the same proportion of the state budget for preventive medicine only.

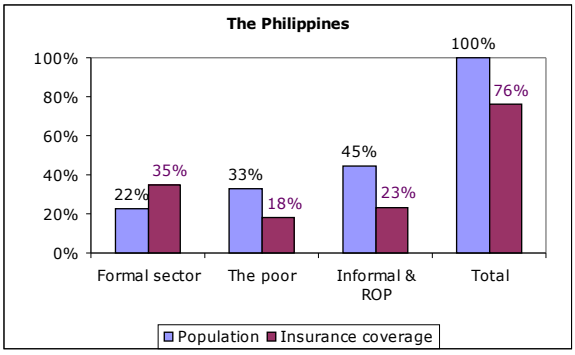
The Plan also intends to improve availability of health service provision by allocating more resources for investing in health in all levels (paragraph 2 of task 4.7), improving efficiency and effectiveness of resource use (paragraph 3), and continue collaboration with international partners through HPG, JAHR, SOI and JANS in order to mobilize more international aids and resources for health in upcoming years.

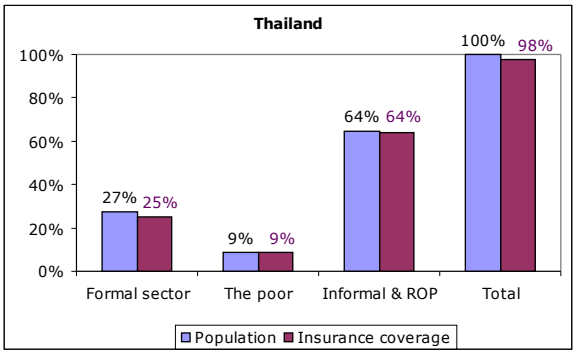
The target to develop universal coverage by 2015 with the coverage of 80% of Vietnamese population is reasonable and sounds feasible because the coverage of health insurance in 2010 is only 60.5% and there is limitation in fiscal capacity of the government to expand health insurance coverage for the informal sector by using tax-finance or tax-subsidy; see Figure 9 on coverage status in relation to selected countries in ASEAN.











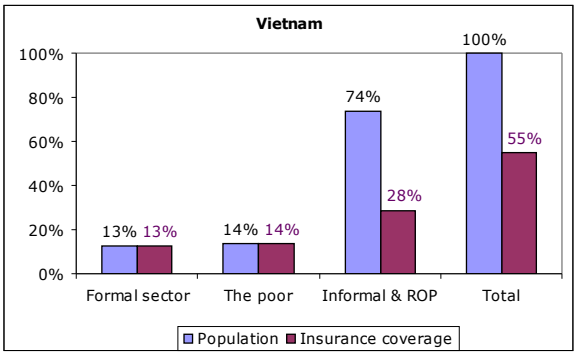


Figure 9 Health insurance coverage, selected ASEAN countries, 2010

The intention of the Plan to control health care costs and reduce the share of out-of-pocket payments require strong political support, effective implementation, evidence for policy decision making, and a good monitoring system. It is predictable to have strong resistance from both public and private providers and other losers such as pharmaceutical and medical device companies.

4.8 Pharmaceuticals and bio-medical products,

The Plan has clear direction and strategy to strengthen development of domestic pharmaceutical industry in producing at least 60% of essential medicines for health care demand of the country. On the quality issue, the targets of 100% achievements in GMP, GLP and GSP are a great policy intention. However, the current gaps to achieve such targets of 100% GMP, GLP, and GSP coverage should be identified and presented. In addition, there is a need for analyzing and identifying key challenges and stakeholders to achieve such targets of quality improvement.

It is concerned that the target to ensure 100% domestic production of vaccines in EPI for infant will be impossible because Vietnam has been applying mixed vaccines 5 in 1 (Diphtheria, whooping cough, tetanus, hepatitis B, and HIB) supported by GAVI since 2010. This advance technology is not easy for Vietnam to develop domestic production capacity in the next five years.

4.9 Medical equipment

The aim and strategy in this task is similar to task 4.8 which aims to strengthen domestic production capacity of medical equipments, and reach the target of minimum provision of 60% of common medical equipments for health facilities in the country. The intention to conduct assessment on current situation and medical device need at all levels is good, but there is a need for the national framework on minimum or basic requirements as well as maximum numbers of medical equipments in each level of health facility. This can be used as the benchmark for quality and efficiency control on resource use by the health facility.

4.10 Strengthening health sector management capacity

In this task, it is vital to strengthening health planning and management capacity at all levels of the health sector. To improve regulatory capacity of the Ministry of Health, and enhance participation of stakeholders in health policy-making, development and implementation of health policies require clear policy strategies and strong commitment from policy makers and all key stakeholders involved with health policy and planning.

Section 5 Some investment programs and projects

This section requires further attention such as consolidating health care network at all levels, implementation of national health target programs (after approval by Prime Minister), health human resource development, pharmaceuticals and medical equipment, health financing and strengthening health sector capacity. In addition, there is a need for identifying linkage between NTP and other specific objectives (goals) of the Plan. It would be better if the NTPs for health, food safety and hygiene, HIV/AIDS prevention and

control would be incorporated in specific objective 4.2, NTP for population-family planning would be included in specific objective 4.4.

Some programs and projects have to be synergistic with related specific objectives in section 4. For example, it is questionable whether the projects on development of specialist medical techniques, and the pilot project on policy and mechanism for specialized medicine development may jeopardize the policy on developing and strengthening grass-root health and primary health care of the country.

Similar to NTP, all investment programs on health financing reforms should be incorporated with specific objective 4.3 which employ health financing strategies to improve quality of health examination and treatment win controllable costs. Also, health financing reforms can be included in specific objective 4.7 on renovating health service operation and financial mechanism to achieve efficiency and equity goals of the health care system.

Section 6 Monitoring, supervision and evaluation,

This section provides roles of different stakeholders in monitoring, supervision, and evaluation of the plan implementation and achievements. It is clear about the roles of Ministry of Health, the National Assembly, provincial health departments, and donors through JAHR. The table of 19 indicators for Provincial Health Departments to monitor, supervision, and report to the Ministry of Health is very useful for coordinate the M&E function of the provincial and national levels.

Section 7 Analysis of risks and difficulties in implementation of the Plan,

The analysis of risks and difficulties in plan implementation is very useful to identify key risks and difficulties with some proposed measures to deal with those risks and difficulties. However, there is a need to include the risk from the uncontrolled growth of market economy and expansion of the private sector which tend to results in inequitable, inefficient, and unsafe health care system. It would be useful if this section would be expanded and discussed among key stakeholders on appropriate measures to mitigate negative impacts from those risks and difficulties.

Section 8 Organization of implementation of the Plan

This section reveals clear roles and functions of different organizations on implementation. This includes MOH, Provincial Health Department, Line Ministries, Ministry of Planning and Investment, Ministry of Finance, Provincial People's Committees, Planning and Finance Department of MOH. However, there is a need for a clear strategy to improve participation, sense of ownership, commitment to implement this Plan from these key stakeholders.

5.3 The application of JANS tools for sub-national plan development in Vietnam [Tien and Oanh]

At provincial level, the JANS tool may be applied to the five year provincial health plan, but not applicable to an annual plan and budget processes. Therefore, our discussion and recommendation will focus on if JANS tool is applicable and is relevant to the Provincial Health Plan. In a decentralized systems, provincial health department take full charges on health matters in their provinces.

- JANS tools, with all 21 attributes, could be very useful tools for assessment of health plan development at provincial level and improvement of the plan quality;
- Provincial health plans that met all JANS attributes would contribute significantly to the national health strategic plan development;
- Application of JANS tools at provincial level has some advantages:
    - The coverage of provincial health sector plan is smaller than national health plan;
    - Better access to local data and information for situation analysis;
    - Most health facilities in provinces are over sighted and supervised directly by provincial health department. Due to this organizational structure, provincial departments can get better engagement and ownership by all partners for plan development.
    - There is a close inter-sectoral collaboration among different provincial departments in most provinces.
- Despite those advantages, there are several challenges, of which the most prominent are following:
    - Official, standard structure of plan document, regulated by the Government does not cover some attributes of JANS tools for which modification is required;
    - Limitation in human resources, in term of capacity for plan development in a number of provinces;
    - Problem of data quality; level of HMIS development was limited in some provinces;
    - Dependence of funding on central government in a number of less wealthy provinces;
    - Little involvement of NGO stakeholders in plan development process due to political characteristics in Viet Nam;

- Applicability:
    - In the first stage, JANS tools could be applied to a number of more advanced provinces; in a later stage, JANS tools to be improved, customized to apply to all provinces

In the following parts description of advantages and challenges related to specific JANS attributes if applied to provincial level. Nomenclature: relevance + means that application of the attribute is relevant to provincial level; relevance – means that the attribute is not relevant.

1. SITUATION ANALYSIS AND PROGRAMMING : Soundness of analysis/assessment underlying identification of the programming contained in the national strategy

Attribute 1: National strategy is based on a sound situational and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, and institutional determinants).

Applicability (+)

- Advantage: Smaller scale of health sector in provinces facilitates a comprehensive situation analysis, availability of local specific health problems.
- Challenge: limitation of capacity for analysis work in some provinces.

Relevance: (+)

Attribute 2: Clearly-defined priority areas, goals, objectives, interventions, and expected outcomes/products that contribute to improving health outcomes and meeting national and global commitments (such as the Millennium Development Goals and WHA resolution on PHC)

Applicability: (+)
- Advantage: Easier to achieve consensus on priority areas at provincial level;
- Challenge: Some provinces may need more experience in priority setting.

Relevance: (+)

Attribute 3: Planned interventions are feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness and sustainability (both financial and programmatic).

Applicability: (-)
- Advantage:
- Difficulty: Attribute 3 – characteristic 1.6: Planned strategies and interventions are upon analysis of effectiveness and impact and clearly identify how they contribute to expected outcomes

  ➔ Necessity but not feasible at local level.
- Challenge:

  + Limitation of capacity for doing this in some provinces.

  + Need of improvement in evidence based policy development and cost effectiveness analysis

Relevance: (+)

Attribute 4: Both assessment of risks (analyzing feasibility of and potential obstacles to implementation) and proposed mitigation strategies (including specifying technical assistance needs) are present and credible.

Applicability: (-)
- Advantage: help to analyse feasibility of and potential barriers to succesful implementation and be able to identify solutions to deal with those barriers
- Challenge: Risk assessment usually not a component of standard health plan; need to be included in the government guideline/regulation on plan development.

Relevance: (+)

2. PROCESS: Soundness and inclusiveness of development and endorsement processes for the national strategy

Attribute 5: Multi-stakeholder (including government) involvement in development of **national strategy** and operational plans (led by government, with a transparent participative process) and multi-stakeholder final endorsement of **national strategy**.

Applicability: (-)
- Advantage:
- Challenge: Little involvement of private sector and professional associations in plan development process, as they are not officially assigned this function. There is a need of a regulation for multi-stake holder final endorsement of plan.

Relevance: (+)

Attribute 6: High level of political commitment (at the highest level) to **national**

strategy.

Applicability: (+)
- Advantage: health plan always to be approved by provincial people councils.
- Challenge:

Relevance: (+)

Attribute 7: National strategy (provincial strategy) consistent with relevant higher- and/or lower-level strategies, financing frameworks and underlying operational plans.

Applicability: (+)
- Advantage:
- Challenge: National strategy should be developed and approved before development of provincial strategic plans. The text should be modified as provincial strategies are consistent with national strategies

Relevance: (+)

3. FINANCE AND AUDITING: Soundness of financial and auditing framework and systems

Attribute 8: Expenditure framework with comprehensive budget/costing of the program areas covered by the national strategy.

Applicability: (+)
- Advantage: Budgeting/costing is a routine at provincial level.
- Challenge: Limitation of government budget, low and not updated cost norm

Relevance: (+)

Attribute 9: Expenditure framework includes financial gap analysis – including a specification of known financial pledges against the budget from key domestic and international funding sources (specification of sources of domestic funds desirable).

Applicability: (+)
- Advantage:
- Challenge: Revenue projections: subsidy for vulnerable population groups is dependent on central government allocation in a number of provinces

Relevance: (+)

Attribute 10: Description of financial management system (including financial reporting against budgeted costs, and accounting policies and processes) and evidence that it is adequate, accountable, and transparent.

Applicability: (-)
- Advantage:
- Challenge: Description of financial management system not included in standard, official structure of strategy document.

Relevance: (+/-)

Attribute 11: Description of audit procedures and evidence of appropriate scope of audit work, as well as independence and capacity of auditors.

Applicability: (-)
- Advantage:
- Challenge: Description of audit procedures not included in strategic plan in current practice; audit procedures must to follow audit law and government budget law.

Relevance: (+/-)

Attribute 12: In the context of national development policies (where applicable): - Explanation of how external resources will be channelled, managed and reported on; - Description of relevant domestic financing policies (in relation to different approaches to resource pooling); - If relevant, description of how fiscal space constraints to scaling-up spending will be managed.

Applicability: (-)
- Advantage:
- Challenge: Description of internal and external financial arrangement is not a part of 5-year strategy, according to the government guidelines.

Relevance: (+/-)

4. IMPLEMENTATION AND MANAGEMENT: Soundness of arrangements and systems for implementing and managing the programs contained in the national strategy

Attribute 13: Operational plans are regularly developed through a participatory process and detail how strategic plan objectives will be achieved.

Applicability: (+)
- Advantage: the PHD will be able to monitor progress towards implementation when the strategic objectives have measurable annual milestones
- Challenge: Provincial Health Departments needs to strengthen their capacity to make operational plans detailed in measurable annual milestones.
- Needs of change current standard of planning process.

Relevance: (+)

Attribute 14: Description of how resources will be deployed to achieve clearly defined outcomes (with attention to staffing, procurement, logistics and distribution. Plan describes transfer of resources [human, commodities] to sub-national level and non- state actors).

Applicability: (-)
- Advantage:
- Challenge: Shortage of funding; official standard structure of plan does not include this characteristics.

Relevance: (+/-)

Attribute 15: Procurement policy that complies with international guidelines and evidence of adequate, accountable, and transparent procurement and supply management systems with capacity to reach target populations.

Applicability: (+)
- Advantage: Procurement policy and procedures clearly defined by MoF and MPI;
- Challenge: Dependence of provinces on national level policy development: national drug policy needs to improve in term of selection of cost-effective medicines and health technology.

Relevance: (+)

Attribute 16: Specification of governance, management and coordination mechanisms/ framework for implementation (describing roles, responsibilities and decision-making of all stakeholders).

Applicability: (+)
- Advantage: PHD is responsible to supervise, manage and coordinate all health

actions in the province
- Challenge: Supervisory and oversight systems need to be improved
- Role of NGO (professional associations) in oversight and supervision not available in current context.

Relevance: (+)

5. RESULTS, MONITORING AND REVIEW: Soundness of review and evaluation mechanisms and how their results are used

Attribute 17: Plan for monitoring and evaluation that includes clearly-described output and outcome/impact indicators, with related multi- year targets that can be used to measure progress and make performance based decisions.

Applicability: (+)
- Advantage: PHD is responsible the M&E of progress according to annual plan
- Challenge: Limitation in capacity of M&E plan development and implementation

Relevance: (+)

Attribute 18: Plan for monitoring and evaluation includes sources of information for indicators and description of information flows.

Applicability: (+)
- Advantage: PHD has better access to local information
- Challenge: Weaknesses in HMIS in many provinces. Plan of M&E not a compulsory part of current provincial health plan.

Relevance: (+)

Attribute 19: Plan for monitoring and evaluation that includes descriptions of data collection/data management methods, tools and analytical processes (including quality assurance).

Applicability: (+)
- Advantage:
- Challenge: Same as above (attribute 18)

Relevance: (+/-)

Attribute 20: There is a plan for joint periodic performance reviews (reporting of results against specified objectives and respective targets explaining any deviations) and processes for the development of related corrective measures.

Applicability: (+)
- Advantage:
- Challenge: Same as above (attribute 18)

Relevance: (+/-)

Attribute 21: Monitoring and evaluation plan describes processes by which monitoring results can influence decision making (including financial disbursement).

Applicability: (+/-)
- Advantage:
- Challenge: Same as above (attribute 18)

Relevance: (+/-)

The following matrix, table XX, summarizes the applicability and relevance of JANS tools for the provincial five year plan development.

Table XX Summary comments on applicability and relevance of JANS tools

JANS attributes	Applicability	Relevance
1.	+	+

2.	+	+
3.	-	+
4.		
5.		
6.		
7.		
8.		

Annex 1 Joint Assessment Tool, attributes and characteristics of attributes

JOINT ASSESSMENT ATTRIBUTES AND CRITERIA		
Attributes	**No.**	**Essential Characteristics of the Attributes**
1. SITUATION ANALYSIS AND PROGRAMMING Soundness of analysis/assessment underlying identification of the programming contained in the national strategy		
Attribute 1: National strategy is based on a sound situational and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, and institutional determinants).	1.1	The situation analysis is based on a comprehensive and participatory analysis of health determinants and health outcome trends within the epidemiological, political, socio-economic and organizational context prevailing in the country.
	1.2	The analysis uses disaggregated data to describe progress towards achieving overall health sector policy objectives in line with the policy dimensions of resolution WHA 2009 62.12 on primary health care: • Universal coverage, to improve health equity • Service delivery, to make health systems people-centred • Public policies, to promote and protect the health of communities • Leadership, to make health authorities more reliable.
	1.3	An analysis of past and current health sector responses identifies priority problem areas and programmatic gaps.
Attribute 2: Clearly-defined priority areas, goals, objectives, interventions, and expected outcomes/products that contribute to improving health outcomes and meeting national and global commitments (such as the Millennium Development Goals and WHA resolution on PHC)	1.4	Objectives are measurable, realistic and time-bound.
	1.5	Goals, objectives and interventions address health priorities, equitable access, quality and health outcomes across all population sub-groups, especially vulnerable groups.
Attribute 3: Planned interventions are feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness and sustainability (both financial and programmatic).	1.6	Planned strategies and interventions are based upon analysis of effectiveness and impact and clearly identify how they contribute to expected results.
	1.7	The plan identifies and addresses key systems issues that impact on sustainability including equity, financial, human resource, and technical sustainability gaps and constraints.
	1.8	Plan describes short- and long-term strategies to meet technical assistance requirements for its implementation.
	1.9	Contingency plans for emergency health needs (natural disasters and emerging/re-emerging diseases), in line with the International Health Regulations, is included in national planning process at all levels.
Attribute 4: Both assessment of risks (analysing feasibility of and potential obstacles to implementation) and proposed mitigation strategies (including specifying technical assistance needs) are present and credible.	1.10	The plan includes a risk assessment of potential barriers to successful implementation.
2. PROCESS Soundness and inclusiveness of development and endorsement processes for the national strategy		
Attribute 5: Multi-stakeholder (including government) involvement in development of national strategy and operational plans (led by government, with a transparent participative process) and multi-stakeholder final endorsement of national strategy.	2.1	A multi-partner mechanism exists, which ensures the lead of the government and the participation of all stakeholders providing input systematically and regularly into all phases of multi-year strategic plan development and all phases of the annual operational planning.
Attribute 6: High level of political commitment (at the highest level) to national strategy.	2.2	All needed sectoral and multi-sectoral policies and legislation, under the spirit of "health in all policies", are in place to allow successful implementation.
	2.3	The plan specifically notes any problems with implementing the needed regulatory and legislative framework and has a strategy to overcome enforcement problems.
	2.4	Political commitment is evidenced by meeting agreed targets in government health related expenditures and by a move towards increasing the proportion of government's financing of the national

		strategy.
	2.5	High-level (e.g. parliament, national assembly) political discussion, agreement and formal endorsement of the national strategy and budget.
Attribute 7: National strategy consistent with relevant higher- and/or lower-level strategies, financing frameworks and underlying operational plans.	2.6	The national health strategy, including disease specific programmes and other sub-strategies are consistent with each other and with overarching national development objectives.
	2.7	In decentralized health systems, there is an effective mechanism to ensure sub-national strategies and processes address all main national-level goals and targets.
3. FINANCE AND AUDITING Soundness of financial and auditing framework and systems		
Attribute 8: Expenditure framework with comprehensive budget/costing of the program areas covered by the national strategy.	3.1	The strategy is accompanied by a sound expenditure framework with a costed plan. It should ensure pertinent recurrent and investment financing of e.g. human resources, access to medicines, decentralized management, infrastructures and logistics.
Attribute 9: Expenditure framework includes financial gap analysis – including a specification of known financial pledges against the budget from key domestic and international funding sources (specification of sources of domestic funds desirable).	3.2	Revenue projections are based upon explicit assumptions, include all sources of finance (local and external) and account for any foreseen uncertainties or risks.
	3.3	Ensure health-financing systems that avoid catastrophic health-care expenditure and impoverishment from result of seeking care; (WHA 2005 58.33)
	3.4	Costing and budget estimates for scaling up equitable services are based on sound economic analysis.
Attribute 10: Description of financial management system (including financial reporting against budgeted costs, and accounting policies and processes) and evidence that it is adequate, accountable, and transparent.	3.5	Financial plans have transparent criteria governing allocation of funds across programmes, including sub-national levels and non-state actors (where appropriate).
	3.6	Financial management system meets national and international standards, as well as produces reports appropriate for decision-making, oversight and analysis.
	3.7	Sufficient staff capacity and skills to provide oversight, detect and prevent unauthorized use of funds at all levels.
	3.8	Sufficient staff capacity and core competencies to ensure efficient disbursement to all levels; and, where appropriate, to different implementing partners.
	3.9	There are formal and systematic mechanisms to ensure timely disbursements and identify fund flow bottlenecks and resolve them.
Attribute 11: Description of audit procedures and evidence of appropriate scope of audit work, as well as independence and capacity of auditors.	3.10	There is an effective fiduciary process, as evidenced by routine internal and external audits of financing, procurement and resources management at all administrative levels.
	3.11	Independence, authority, skills and competencies of auditors meets national and international standards.
	3.12	Audit system assures performance is routinely assessed against "value for money".
	3.13	A parliamentary or other public accounts auditing committee credibly investigates alleged irregularities. Appropriate sanctions are applied.
Attribute 12: In the context of national development policies (where applicable): - Explanation of how external resources will be channelled, managed and reported on; - Description of relevant domestic financing policies (in relation to different approaches to resource pooling); - If relevant, description of how fiscal space constraints to scaling-up spending will be managed.	3.14	Plan clearly describes all internal financial arrangements and funding modalities, and how internal and external funds will be channelled, managed and reported on.
	3.15	Plan has explicit guidance on how programmes will manage fiscal space constraints to scaling up.
4. IMPLEMENTATION AND MANAGEMENT Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy		

Attribute 13: Operational plans are regularly developed through a participatory process and detail how strategic plan objectives will be achieved.	4.1	Roles and responsibilities of implementing partners are described for each strategy and intervention.
	4.2	Each strategic objective has measurable annual milestones to assess progress towards implementation.
Attribute 14: Description of how resources will be deployed to achieve clearly defined outcomes (with attention to staffing, procurement, logistics and distribution. Plan describes transfer of resources [human, commodities] to sub-national level and non-state actors).	4.3	The organization of service delivery is defined and identifies equitable allocation of resources (recurrent, investments) by level of care and roles and responsibilities of service providers; including plans for referrals and supervision.
	4.4	Human resource (management and capacity) needs are identified, including staffing levels, skills mix, training, supervision and incentives. Gaps needed to implement the national strategy are identified and a plan provided to solve identified gaps.
	4.5	Current logistics, information and management system constraints are described, and credible actions are put in place to resolve constraints.
Attribute 15: Procurement policy that complies with international guidelines and evidence of adequate, accountable, and transparent procurement and supply management systems with capacity to reach target populations.	4.6	Procurement and supply management (PSM) policies, strategies and systems in place to assure universal access to safe, effective and good quality pharmaceuticals and commodities.
Attribute 16: Specification of governance, management and coordination mechanisms/ framework for implementation (describing roles, responsibilities and decision-making of all stakeholders).	4.7	Internal and multi-stakeholder external governance arrangements exist that specify management, oversight, coordination, and reporting mechanisms for plan implementation.
	4.8	Plan describes in detail supervisory and oversight systems to oversee resource use and HR management at all levels.
	4.9	National government governance policies include a description of accountability, oversight, enforcement and reporting mechanisms within the Ministry and relevant departments.
5. RESULTS, MONITORING AND REVIEW Soundness of review and evaluation mechanisms and how their results are used		
Attribute 17: Plan for monitoring and evaluation that includes clearly-described output and outcome/impact indicators, with related multi-year targets that can be used to measure progress and make performance based decisions.	5.1	There is a detailed performance based framework for monitoring and evaluation that includes valid and collectable output, outcome and impact indicators.
Attribute 18: Plan for monitoring and evaluation includes sources of information for indicators and description of information flows.	5.2	M&E of implementation uses HMIS, survey and other epidemiological data disaggregated by major determinants of health as well as data on resource allocation.
	5.3	Monitoring and evaluation plan components includes a description of information flows and gaps, sources, methodologies and processes.
Attribute 19: Plan for monitoring and evaluation that includes descriptions of data collection/data management methods, tools and analytical processes (including quality assurance).	5.4	Critical gaps and weaknesses in M&E plan implementation are identified and an explicit strategy to overcome these is described and costed.
	5.5	The plan details the roles and responsibilities at all levels for each required data management components.
Attribute 20: There is a plan for joint periodic performance reviews (reporting of results against specified objectives and respective targets explaining any deviations) and processes for the development of related corrective measures.	5.6	M&E system is regularly assessed for how well it monitors progress and generates needed information.
	5.7	A multi-partner (independent, when required) review mechanism inputs systematically and regularly into assessing sector or programme performance against annual and long-term goals.
	5.8	The plan details credible, multi-stakeholder mechanisms to provide routine feedback on performance to sub-national and non-state providers.

Attribute 21: Monitoring and evaluation plan describes processes by which monitoring results can influence decision making (including financial disbursement).	5.9	M&E components of plan detail how results from performance analyses will formally be incorporated into future decision making; including resource allocations and financial disbursements to programmes and sub-national levels.

Annex 2 Structure of the Plan Draft 4

Background
Part I an assessment of implementation of the health sector development plan during 2006-2010
1. Health status and determinants
    1.1. Basic health indicators
    1.2. Disease morbidity and mortality
    1.3. Health determinants
        1.3.1. Population related factors
        1.3.2. Globalization, industrialization, urbanization and migration and chaning lifestyles
        1.3.3. Climate change
        1.3.4. Environmental health
        1.3.5. Lifestyle determinants
        1.3.6. Injuries, accidents
2. Preventive Medicine
3. Examination and treatment, and rehabilitation
4. Population, Family Planning and Reproductive Health
5. Human resources for health
6. Health Information Systems
7. Pharmaceuticals, vaccines and blood
8. Medical equipment and technology
9. Health financing
10. Governance
11. Implementation of health indicators
12. Priority issues to be addressed

PART 2 five-year health sector development plan 2011-15
1. Opportunities and challenges
    1.1. Opportunities
    1.2. Challenges
2. General objectives
3. Basic health indicators
4. Key tasks
    4.1. Consolidating, developing network of examination and treatment, especially the grass-root health
    4.2. Strengthening preventive medicine, national target program for health
    4.3. Consolidating, developing and improving quality of health examination and treatment
    4.4. Strengthening population and family planning
    4.5. Developing health human resources
    4.6. Developing health information system
    4.7. Renovating health service operation, financial mechanism
    4.8. Pharmaceuticals and bio-medical products
    4.9. Medical equipment
    4.10. Strengthening health sector management capacity
5. Some investment programs and projects
6. Monitoring, supervision and evaluation
7. Analysis of risks and difficulties in plan implementation
8. Organization of implementation

Annex 3 Comments on the process and content of the Plan draft 3 by five dimensions and 21 attributes

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
Dimension 1 SITUATION ANALYSIS AND PROGRAMMING Soundness of analysis/assessment underlying identification of the programming contained in the national strategy		
Attribute 1 National Strategy is based on a sound situational and response analysis of the context		
Attribute characteristic 1.1 The situation analysis is based on a comprehensive and participatory analysis of health determinants and health outcomes trends within the context of the country	**Participation**: There has clearly been a great effort on the part of MOH to better integrate the Joint Annual Health Report-JAHR and the Plan. The plan has successfully identified a number of important issues to be covered. Analysis and inputs for the Plan is more comprehensive and participatory than previous plan 2006-10. Key informants endorse strong participation and engagement by stakeholders in producing JAHR: DPF together with JAHR working group developed JAHR report framework, organized workshop with participation by HPG, Various dept of MOH and related stakeholders provide comments, recruitment of national consultants for each specific areas of JAHR, writing up a report and organized 3 workshops to get comments (one WS discussed the difficulties, constraints and challenges of health care system; one discussed on priority setting for next 5 years; one on identification of solutions and interventions. Various dept of MOPH also contribute to the situation assessment, though they describe situation of their routine works but not focused on problem identifications and other health system context. It is one of difficulties that the planning team have to face with. After three workshops between Planning Team and JAHR teams, there were increased linkages and dialogues. Especially the JAHR WS on setting priorities, outputs from WS were sent immediately to the planning group. Vice versa, the outputs of the WS organized by the Planning Group on solutions were fed back to JAHR Team. In the workshop, indicators were identified which are appropriate	Despite significant progress, while maintaining stronger participation by existing stakeholders, expansion to others are important and ensure relevance e.g. Social Committee of the National Assembly, Consumer representatives, professional groups, private sector, education and other relevant sectors, representatives from grass-root levels.

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	with both priorities identified in JAHR and objectives of 5 year health plan.	
	Comprehensiveness JAHR furnishes based on (i) assess current situation; (ii) identify priorities of the health sectors; (iii) support for developing annual health sector plan. Annual JAHR exercise focus each year on thematic topics. JAHR 2010 aims to provide inputs for the development of the Plan, it looks at 6 health systems building blocks. However, analysis of indicators and determinants are still not comprehensive enough to show the actual causes behind those indicators and determinants. For example, the analysis shows there are large disparities between regions in some of indicators such as IMR, child malnutrition but did not assess the reasons for that. Similarity for analysis of health determinants, it focuses on listing health determinants but not much on pointing out their root causes such as social, cultural, economic and especially organizational/system context.	Analysis of determinants could be improved considerably based on existing studies and surveys. Understanding the actual cause behind those indicators and determinants is important and will be helpful in justifying planned interventions. It is necessary to demonstrate geographical disparities and its causes of MMR for specific interventions in the Plan. Health determinants: comprehensive analysis of physical and social-cultural-economic, ethnicity, education, gender determinants. Note that injuries and accidents are health outcomes, not determinants.
Attribute characteristics 1.2 The analysis uses disaggregated data to describe progress towards achieving overall health sector policy objectives in line with the policy dimensions of resolution WHA 2009 62.12 on primary health care: Universal coverage, to improve health equity, Service delivery, to make health systems people-centred, Public policies, to promote and protect the health of communities, Leadership, to make health authorities more reliable.	Draft 3 did not adequately describe progresses towards achieving overall health sector policy objectives in line with the policy dimensions of resolution on PHC.	Need to be added in draft 4, though some parts are reflected in the human resources development
Attribute characteristics 1.3. Identification of priority problem areas and programmatic gaps	Priority problems and solutions are identified separately by specific areas. The causes of those priority problems are not well assessed in the situation section. It is necessary to look at specific problems in the context of health system to devise specific and effective policy interventions. Though a number of key issues have been identified, HPG suggest there should be a stronger inter-relationship and interactions across different key issues. The lack of integration across different areas (partly as a result of financing flows to different sub-sectors) represents one of the major weaknesses in the health system, In large part due to the fact that a number of vertical programs are	It would be important for the situation analysis to better prioritize key issues to be addressed. Among the seven building blocks [pharmaceutical and vaccines are separate item from the medical equipment] and three other issues in section 12, what are the priority and major entry point, given that resource might not be available to address all of them??

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	operating in parallel with each other, and are not well-integrated in terms of implementation as well as management. As Vietnam has reached middle income country status, these issues will become increasingly important over the next five years. As donor funding to health start to decline, it is important for the Government to consider ways in which efficiency can be improved. Where some programmes that still do not achieve indicators as targeted, it is necessary to analyse reasons for that of which referring to its implementation. Section 12 describes the priority issues to be addressed, the Plan proposed 10 areas, seven out of ten are health systems building blocks and three other health issues, namely family planning, health status and disparities and preventive medicines at primary health care level are highlighted. It is unclear how these were prioritized. There is no clear process on the priority setting	
Attribute 2 Clearly-defined priority areas, goals, objectives, interventions, and expected outcomes that contribute to improve health outcomes and meeting national and global commitment.		
Attribute characteristic 1.4 Objectives are measurable, realistic and time-bound.	The objective described in Draft 3 is rather general. It said, "to reduce morbidity and mortality, promote health and increase life expectancy, improve the quality of our race, contribute to improving the quality of life, the quality of the human resources, foster the formation of a synchronized system of healthcare from the central to the grass-roots levels and people's habit of keeping good health, in response to the needs of industrialization, modernization, national building and defences. It is felt that the objectives and target indicators by 2015 is realistic, however, hospital bed per 10,000 inhabitants (exclude CHS bed) would increase from 20.5 to 23.0, this means around 21,000 new beds would put in place by 2015. There is a need to ensure that this target is realistic. The Reduction in MMR from 68 in 2010 to 58.3 by 2015 need a statement that this would be achievable. It would be extremely difficult to increase population coverage on insurance from 60% in 2010 to 80%	It is necessary to provide specific objectives of the plan of which measurable, realistic and time-bound criteria need to be taken into the consideration, although the target to achieve by 2015 is clearly written in Table under section 3 on Basic Health Indicators. There is a need to plan for adequate number of health workers to operate these beds and retain them in public health sector. It is not clear on what are the policy interventions on rural retention and increase enrolment of new graduates in rural health services.

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	in 2015 due to nature of the contributory scheme for the informal sector despite the high level of budget subsidies.	
Attribute characteristic 1.5 Goals, objectives and interventions address health priorities, equitable access, quality and health outcomes across all population sub-groups, especially vulnerable groups.	Goal, objectives, results and key interventions are not well structured. It is not clear how prioritization was done, what strategies and specific interventions will be carried out and how they will respond to the needs of vulnerable groups (age, gender, wealth, urban/rural). Also, it is not clear what effective interventions would be chosen to meeting national/global commitments. Though a number of priority areas are identified, these remain broad and seemingly cover the range of interventions included in the plan. Subsequently, interventions are not systematically organized and appear to be a listing of existing/planned projects/programs in the sector. This is because the situation analysis does not provide sufficient in-depth analysis in certain key areas, therefore, the real cause of the problem is often not considered in a systematic way. Although there is no systematic burden of diseases study in Vietnam, routine statistics shows that chronic NCD is increasingly a major problem of disease and economic burden. Unfortunately, there is no priority program to address the chronic NCD. References on cost effective clinical and community based interventions should be referred from the DCP2 [35]. There is a sporadic reference to chronic obstructive pulmonary disease which is attributable to tobacco use. There is a need to address how Vietnam would bring down prevalence of regular smoker and better protection health of the non-smokers, enforcement of smoke free environment. Although the need to improve primary health care is described, there appears to be no clear strategy concerning how this will be done. For example, there is no reference to the linkages/interaction between different levels of care (especially primary and secondary, in order to offer a comprehensive package of care to the population (particularly those disadvantaged groups and ensure proper referral backup services at the provincial level) or how to make patient-centred care as well as how to make health care	It is necessary to address health priorities, equitable access, quality and health outcomes across al population sub-groups, especially vulnerable groups in the objectives and interventions. It should better focus the perspective of patient-centred care, and linked with this a more holistic approach to PHC, for example the development of Patient Right or Charter, and empowerment of consumer protection groups. DPF should include Intervention to improve health governance and support MOH and its sub-national system and strengthen capacity to undertake more and better its stewardship role Suggest that influenza, rabies, cholera and acute watery diarrhoea are added under the section on preventive medicine. Also suggest a specific reference to preparedness for complex public health emergencies including pandemics, and strengthening diseases surveillance and coordination between human and animal health. At the end of the section on preventive medicine, suggest adding a sentence on multi-sector coordination on complex health issues, including multi-sector pandemic preparedness. A new priority program on effective intervention to prevent and control chronic NCD should be provided.

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	becomes universal coverage. Due to lack of in-depth analysis of the context in identifying causes of priority problems and programmatic gaps, therefore, there is no specific programmes to improve health governance and support MOH and its sub-national system to strengthen capacity to undertake more and better stewardship role when it is seen as crucial in the next five year. This also includes more detailed activities in strengthening the legal framework. The private sector has been touched on briefly, but no specific or concrete programs/interventions to harness the potential of private sector in health care (other than a relatively general statement on developing mechanisms to strengthen collaboration with the private sector. Careful management of the growing magnitude or private sector is so critical in various dimension, e.g. universal coverage, human resource migration dynamics, inefficiency and potential supplier induced demands and catastrophic health expenditure to the households	
Attribute 3 : "Planned intervention are feasible, locally appropriate, equitable and based on evidence and good-practice, including consideration of effectiveness and sustainability"		
Attribute characteristic 1.6 Planned strategies and interventions are based upon analysis of effectiveness and impact and clearly identify how they contribute to expected results.	Planned strategies and interventions are not clearly reflect that they are based on analysis of effectiveness and impact.. There is no reference how these interventions contribute to expected outcomes.	Given there are a number of programs that have been implemented over the last five years and these programs are found to be implemented again in this plan without specificity of where or not they are truly effective and necessary to be maintained. An critical assessment of the programmatic outcome are important foundation to guide better interventions.
Attribute characteristic 1.7 The plan identifies and addresses key systems issues that impact on sustainability including equity, financial, human resource, and technical sustainability gaps and constraints.	Interventions are described as Key Task under section 4 of part II of the Plan. **Feasibility:** From a technical point of view, the current listing of interventions is not sufficient to guarantee the feasibility of the plan because concrete interventions on "how to do" are not clearly defined. **Appropriateness & effectiveness:** Interventions presented appear to be appropriate despite the need for a greater linkage between them. **Equity:** equity is only partially considered in the Plan. In other	The interventions need to be clearly identified based on more in-depth (causal) analysis

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	words, it is not clear how the plan would minimize the geographical inequity in IMR and child malnutrition (table 1 and 2 of the Plan). There is a need to refer to Intersectoral Action, such as education and improved female literacy rate which have a major bearing on health of children. Economic development, poverty reduction and equitable income distributions are important contribution to health equity goals. **Sustainability:** without formal assignment of responsibility to Department concerned on implementation and adequate financial commitment, it is unlikely that interventions will be sustainable.	
Attribute characteristic 1.8 Plan describes short- and long-term strategies to meet technical assistance requirements for its implementation.	There is no assessment on the requirement of technical assistance in the Plan.	Further analysis may be needed to determine which of the interventions require technical assistance
Attribute characteristic 1.9 Contingency plans for emergency health needs (natural disasters and emerging/re-emerging diseases), in line with the International Health Regulations, is included in national planning process at all levels.	Contingent plans for emergency health needs in case of natural disaster, major disease outbreaks are still not included in the Plan	Contingent plans for emerging threats, pandemics and complex emergencies need to be included or referred to if there are these plans elsewhere.
Attribute 4: Both assessment of risks and proposed mitigation strategies are present and credible		
Attribute characteristic 1.10 The plan includes a risk assessment of potential barriers to successful implementation.	The Plan does not appear to have formal risk assessments and mitigation strategies are not well-defined. One key barrier in achieving 80% population coverage with prepayment scheme is the contributory nature for the informal sector where enforcement and contribution collections are difficult. There is a need to identify barriers and risk to achieving goals of the ten Key Tasks in section 4 of Part II of the Plan, and how to mitigate these barriers	Risk assessments should be addressed in draft 4 that all potential risks are well aware and plan to mitigate these risks are well thought out. Risk assessment should be examined not only from health sector perspective, risks and challenges are also examined from economical and social, natural environment perspectives.
Dimension 2 PROCESS Soundness and inclusiveness of development and endorsement processes for the national strategy		
Attribute 5: Multi-stakeholder (including government) involvement in development of national strategy and operational plans (led by government, with a transparent participative process) and multi-stakeholder final endorsement of national strategy.	Positive steps have been taken by MOH in adopting a new approach to planning based on openness, transparency, engaging and more participatory. The application of WHO six health systems building blocks in the construct of the Plan sound reasonable and useful in strengthening health systems, the vital contribution to good health of the population.	Add one section to document the process how the Plan was gradually developed to demonstrate the level of involvement and participation by stakeholders

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	Genuine partnership between JAHR and Planning team and efforts in involving provincial health bureaus in the Plan development processes in a bottom up manner were appreciated by key informants. However, only 20% of provinces and cities submitted their provincial five year plan to the MOH. Influenced by the vertical nature of their program, the level of involvement by some MOH departments are not high, with limited commitments. At times, they comment only their Department's mandate without concerns over the Plan as a whole. MOH officials perceive annual health plan more important than the five year plan.	
Attribute 6: High level of political commitment (at the highest level) to national strategy.	In general, key informants indicated that the Plan was developed based on the direction and guideline of relevant policies, strategies and related regulations. There are verbal financial commitment by political and government agencies but it is difficult to predict the level of annual budget, and limitation of other legal framework. Integral part of the Plan contributes to the development of health chapter of the National Socio-Economic Developments Plan compiled and synthesized by the Ministry of Planning and Investment. This demonstrates highest level commitments on the Plan. The regulatory framework for developing and implementing the plan is clear. Implementation issues may arise if ownership is not present (defined as active involvement/oversight of development and adoption in day-to-day management activities) of the Plan by the MOH as a whole.	
Attribute 7: National strategy consistent with relevant higher- and/or lower-level strategies, financing frameworks and underlying operational plans.	MOH Departments, National Targeted Programs, and the Provinces each developed their plans based on guidelines and templates provided by the DPF. These plans apply similar formats. DPF staff summarized and incorporated in to the 5 year plan. However DPF could not control the orientation and quality of these Provincial Plans and NTP. Departmental Plan, the National Targeted Programs were developed in consistent with the national strategies and policies relevant to their areas. Full involvement and contributions	Full involvement by other MOH departments and NTP, and reflection in the plan of sub-sector strategies currently being developed. Though those strategies may not yet be completed and approved, it would be very helpful for the plan to draw on these, in order to ensure full consistency. Further extension of consultation with ample time to allow inputs provided by a broad range of stakeholders such as professional groups, private sector, education and academic institutions.

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	by Provincial Health Bureaus is materialized when their inputs were well reflected in the Plan. Bottom up ensure relevance and inter-relationship between the national and sub-national plans.	
Dimension 2 Finance and Auditing - Soundness of financial and auditing framework and systems		
	- Although the planning process has been robust, there is room for improvement in the linkages between the strategy, expenditure planning, and resources; including with MTEF;	
Attribute 8. Expenditure framework with comprehensive budget/costing of the program areas covered by the national strategy		
Attribute Characteristic 3.1. The strategy is accompanied by a sound expenditure framework with a costed plan. It should ensure pertinent recurrent and investment financing of e.g. human resources, access to medicines, decentralized management, infrastructures and logistics.	Budget plan attached to Draft 3 is not in the budget plan template that will be attached to the final version. Comments focus on process of budget development, not on the attached budget draft 3. Key informants said the budget plan was developed for all programme areas, including cost details of all systems support areas such as human resources, infrastructure, medicines and equipment and logistics. Recurrent budget is based on standard cost norm (which is always unrealistically low). But budget breakdown to each category of spending (human resources, medicines etc.) is not clear in the budget table attached to draft 3. National health accounts are not widely used in development of provincial 5 year health plan. Budget plan in draft 3 does not provide cost details of systems support areas such as human resources, infrastructure, medicines and equipment and logistics. There is no description of linkage between priority tasks of the Plan and budget plan, therefore there is de-linkage between priority setting and budgeting. Vietnam has very decentralized health care system, in which budgeting is also decentralized according the budget law. Each province develops their own health budget proposal in line with national strategy, to be approved by Provincial People Council. The multi-year budget has been developed for the decentralized structures (provincial health sector). MOH budget plan consists	In addition to government-defined standard format of budget plan, additional budget table should be attached to the 5-year plan should in order to clarify the JANS attributes 8 and 9 5-year budget plan should provide comprehensively coverage of central and provincial budget; A linkage between priority tasks and budget should be made more explicit in budget plan; Budget scenarios in areas of high degree of unpredictability should be provided

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	of budget of NTP, all its Departments, health facilities and institutions under the MOH jurisdiction. The current draft budget does not show details of budgets for Provincial health systems. As required by the Prime Minister in Directive N. 751 on 5 year SEDP preparation, MOF sent very detail budgeting and reporting templates and guidelines to all sectors, including health sector for development of the Plan. The 5-year health budget plan (not yet attached to draft 3) is based on log frame sent to all provinces and all MOH departments. Not all provincial health departments sent back the log frame with filled in budget information. MOH does not have adequate information regarding annual plans, budgets and resource allocation of provinces MOH also used expenditure data from MOF. The Provincial financial reports (standard template) are submitted to MOF by October each year. Key information report that different budget scenarios for areas of high level of uncertainty were not prepared (not common in current practice) and can not be found in current budget plan (draft 3)	
Attribute 9: "Expenditure framework includes financial gap analysis – including a specification of known financial pledges against the budget from key domestic and international funding sources (specification of sources of domestic funds desirable)."		
Attribute Characteristic 3.2. Revenue projections are based upon explicit assumptions , include all sources of finance (local and external) and account for any foreseen uncertainties or risks.	There was calculation of revenue projections, based on estimated allocation of government funding. No calculations on revenue from health insurance has been provided and discussed, neither analysis of revenue by low, medium and high funding scenarios. There was process for trying to gather data on possible revenue from government funding sources and external sources, but not from health insurance funds, where by Law, universal coverage should be achieved by 2014. Missing funding from VSS is a major weakness of this section. Calculations of potential revenue	Provide estimate of revenue from other sources especially health insurance fund, user fee collections in different scenarios of insurance coverage; Provide calculations of potential revenue on a multi-year period by source, with beginning and periods for each source of funding Provide analysis on bed-based government budget allocation and suggest more advanced options

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	for a multi-year period by source, are not provided in the current budget plan. At provincial level (Hanoi as an example), only revenue from government budget is reflected in overall revenue projections, no other sources provided Government budget allocated for recurrent health care budget is based on capitation principle (according to the Prime Minister Decision N. 151/2006/QD-TTg and N. 219/2006/QDD-TTG). Recurrent budget for each hospital is based on number of beds in given hospitals, while recurrent budget for preventive care in estimated based on capitation formulae.	
Attribute Characteristics 3.3. Ensure health financing systems that avoid catastrophic health care expenditure and impoverishment from result of seeking care	Health insurance law ensured most the poor and ethnic minorities living in disadvantaged areas (about 15 million persons in 2009) are covered by health insurance scheme through full subsidies by the government. The near poor households are eligible by compulsory health insurance scheme, with 50% premium subsidized by government budget, but there is no effective mechanism to increase high level of enrolment, results in adverse selection; members have higher utilization and chronically ill. There is no suggestion on how to achieve universal coverage of health insurance by 2014, as stipulated in the Health Insurance Law. High level of informal payment as well as unlimited co-payment under current health insurance policy is likely to result in impoverishment from seeking care.	Develop policy/strategy to ensure coverage of the near poor and informal sector. Develop policy and strategy to discourage the informal payment; setting the maximum of ceiling of copayment preventing catastrophic health expenditure and impoverishment. Develop policy/strategy to achieve universal coverage.
Attribute Characteristics 3.4. Costing and budget estimates for scaling up equitable services are based on sound economic analysis	There is neither economic analysis, nor costing and budgeting estimate for scaling up key program activities	Include economic analysis and cost models for scaling up priority programmes.
Attribute 10: Description of financial management system (including financial reporting against budgeted costs, and accounting policies and processes) and evidence that it is adequate, accountable, and transparent.	The Country PFM Generally meets the requirements, but moderate to substantial risk exist. The 5-year plan partially meets the disclosure requirement of JANS as it does not yet have discussions regarding the Finance and Audit aspects. Some improvements can be introduced in the plan and the applicable FM arrangements be discussed and references made to relevant	Health financing and audit section needs to be included in the document. It could discuss ways to expand the health resource base and its management in the future taking into account current and future developments in health financing. For instance, it could provide ways to guide non-government resources to attain national health goals. It could

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	specific regulations and other existing documents	include alternative health financing options. The information thus generated could be used to plan the effective use of those resources
Attribute Characteristics 3.5. Financial plans have transparent criteria governing allocation of funds across programmes, including sub-national levels and non-state actors (where appropriate)	- Financial allocation criteria across sub-national levels are fairly well defined and known to all (via Prime ministers letter). Resource allocation negotiations between sectors takes place at provincial level and transparent mechanisms are used. - Since the provinces are fully independent, their prioritization may defer from the national priorities for the health sector.	The government may wish to consider a contractual arrangement in order to ensure that the national strategy and priorities are consistently applied at lower levels and the allocation of resources reflects those priorities
Attribute Characteristics 3.6 Financial management system meets national and international standards, as well as produce reports appropriate for decision-making, oversight and analysis	- Meets substantially the National and Partially International Standards. The spending units produce quarterly and annual reports within reasonable time. The MOH central unit consolidates those reports annually, albeit 11 months after the end of the FY - Financial Management System, which substantially meets the national standards, is in turn partially consistent with the international standards of reporting. It does not seem to systematically produce management reports but rather ad-hoc and as requested. The MOH consolidates the annual reports 11 months after the end of the FY which is slightly later than national requirement but below international standards. There seems to be also a difference between the spending units accounting principle and the treasury (the former is modified cash/modified accrual and the latter is cash basis) that needs to be understood and resolved.	As suggested above, the plan should establish clear responsibilities for financial reporting and needs in terms of frequency and content of the reports for each level and the compilation/consolidation process and responsibilities
Attribute Characteristics 3.7. Sufficient staff capacity and skills to provide oversight, detect and prevent unauthorized use of funds at all levels.	Meets substantially in light of the treasury staff function and capacity – The financial instructions are clear and the segregation of duties between the spending units and the treasury which handles funds is in general a robust control. On the other hand, we concluded that the “Internal Audit” exists only partially The “Internal Audit” can be considered as only very partially existent. It takes the form of annual verification by staff from the MoF verifying the annual reports and random checking of expenditures. There are several other controls by different organs of government, but the	- We suggest that, in consultation with the central ministries, the plan provides clear internal audit framework and procedures that deters mismanagement and ensures detection of internal control weaknesses

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	effectiveness is not evident	
Attribute Characteristics 3.8. Sufficient staff capacity and core competencies to ensure efficient disbursement to all levels; and, where appropriate, to different implementing partners	The reconciliation between the spending units and the payments by the national treasury has been reported to be problematic across the sectors and provinces. However, we were informed that this is done correctly and monthly by MOH and DOHs in provinces;	This issue deserves further review at the spending units at the provincial level as the health sector would be a good model for other sectors and the use of the national system would become a real possibility for the Health sector, should the reconciliation be practiced on a monthly basis
Attribute Characteristics 3.9. There are formal and systematic mechanisms to ensure timely disbursements and identify fund flow bottlenecks and resolve them	It is not clear how the treasury staff prioritize payments in periods of cash short falls and competing demands for payment (eg. between paying salaries or the suppliers).	This is also an area for further review at the provincial and district level at the treasury units. No systematic mechanism to identify bottlenecks and their resolution were reported
Attribute 11: Description of audit procedures and evidence of appropriate scope of audit work, as well as independence and capacity of auditors.	Country situation partially meets the requirements; the plan is silent on the subject	
Attribute Characteristics 3.10. There is an effective fiduciary processes, as evidenced by routine internal and external audits of financing, procurement and resources management at all administrative levels	Meets partially - the external audit is performed by the SAV every other year providing partial audit; the internal audit is done once a year before the consolidated financial reports are issued. This is also considered as very partial internal audit. The procurement risk has been assessed by the World Bank and by other DPs [progress towards the use of country system seems to have stalled - to be completed]	The external financial audit would need to become annual without any audit gap and be complemented with “value for Money” and Procurement audits; the role and attributes of the inspectorates and verification bodies need to be better clarified in the laws. We recommend that the use of carefully selected qualified private sector auditors be considered as complement tot he SAV audits
Attribute Characteristics 3.11. Independence, authority, skills and competencies of auditors meets national and international standards	Partially adequate- the capacity and competency of SAV auditors has been improving but still partial	The external financial audit would need to become annual without any audit gap and be complemented with “value for Money” and Procurement audits; the role and attributes of the inspectorates and verification bodies need to be better clarified in the laws. We recommend that the use of carefully selected qualified private sector auditors be considered as complement tot he SAV audits
Attribute Characteristics 3.12. Audit system assures performance is routinely assessed against "value for money"	Partially adequate- the capacity and competency of SAV auditors has been improving but still partial	Many private sector audit firms have good capacity and comply with the international standards. As an interim measure, they can be used to complement the SAVs capacity
Attribute Characteristics 3.13. A parliamentary or other public accounts auditing committee credibly investigates alleged irregularities. Appropriate sanctions are applied	Meets very partially – The SAV does from time to time include in its work the performance angle while its audits are mainly planned as performance and financial	Given the workload of SAV and level of staffing, the SAV could sub-contract the audit work to private auditors, under its responsibility. Moving forward, and as an interim measure, we recommend that this type of audit for DPs be contracted out to private auditors
Attribute 12: In the context of national development policies (where applicable): - Explanation of how external resources will be channelled, managed and reported on; - Description of relevant domestic financing	Plan Partially meets the JANS criteria both in terms of describing the internal financial arrangements and flows and the fiscal space constraints	

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policies (in relation to different approaches to resource pooling); - If relevant, description of how fiscal space constraints to scaling-up spending will be managed.		
Attribute Characteristics 3.14. Plan clearly describes all internal financial arrangements and funding modalities, and how internal and external funds will be channelled, managed and reported on	- Plan does not describe ; - While on-budget resources are discussed, planned and monitored, there are external resources that flow directly to some provinces. Allocation of these resources is not transparent. As a result, there could be duplication of efforts. Similarly, fund flows from households are not well known. Whether or not such resources contribute towards attaining national health goals is not clear	– the finance and auditing section would need to be added as per JANS guidelines - The DPs who directly provide funding are advised to disclose fully their contributions and the priorities they are aiming. The plan should attempt to include "all resources" on or off budget and try to map resources to priorities and expenditures and develop scenarios showing how/where would potential additional funding be directed for scaling up
Attribute Characteristics 3.15. Plan has explicit guidance on how programmes will manage fiscal space constraints to scaling up	Meets very partially. Plans to overcome fiscal space constraints are not in place	The document would need to discuss beyond budgetary resources
Dimension 3 - Financing and Auditing: Cross-cutting STRENGTH	• The 5-year plan highlights resource inadequacy and revenue short fall for which funding source is not known. • There is increasingly a transparent process and criteria for allocation of resources. Workshops and consultations have been organized to reach consensus for allocation of resources in 4 categories of provinces (namely in urban area, plain area, mountainous – minority ethnic residential area, highland & island area). • The costing of all activities is presented in a useful and easy to understand manner. • The PFM system has a strong separation between the budget holder and payment system in the treasury system which controls and if legitimate makes payments. The budget holders do not receive funds or make payments directly (except for the DP projects with PMUs and designated accounts exist). • Many years of detail planning and several years of MTEF piloting and other Public Financial Management Reforms under implementation by the GOV has already benefited the sector (eg. TABMIS deployed in about 35 Provinces and the central MoH with plans going forward to complete full deployment by end 2011).	

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	• Despite the fact that the plan document doesn't include much on financial management and audit, as expected by JANS guidelines, the planning process has been very robust. • With the results from many studies and workshops/exercises, weaknesses and issues related to financial planning are known to the management which would help their resolution	
Dimension 3 - Financing and Auditing: Cross-cutting WEAKNESSESS	• Although the planning process has been robust, there is room for improvement in the linkages between the strategy, expenditure planning, and resources; including with MTEF. • The Plan document does not have enough description or cross reference to other documents regarding financial management and audit. The health financing and audit section needs to be expanded and adequate reference be made to other existing documents. • Alternative government and non-government financing options are not adequately discussed. The plan should have adequate analysis and discussion of such options. • MOH does not have adequate information regarding annual plans, budgets and resource allocation of provinces. This is a weakness for management decision making that would be resolved once the MoH is given access in TABMIS. Same comment applies to the reporting on the budget execution, due to delayed reporting and consolidation of information. • Analysis concerning health financing is not effectively linked with priorities and targets. The section on health financing describes shortcomings but no suggestion and alternative options to overcome has been given; the linkages and solutions to overcome the shortcomings are critical. We haven't been given any material on this issue other than the 3rd draft of the 5 year HSDP. [Could there be more somewhere else?] • Resource prioritization is unclear - whether it will be based on the resource envelope or what is achievable	• Health financing and audit section needs to be included in the document in a succinct manner with reference to other documents which have more specific details. It could discuss ways to expand the health resource base and its management in the future taking into account current and future developments in health financing. For instance, it could provide ways to guide non-government resources to attain national health goals. It could include alternative health financing options. The information thus generated could be used to plan the effective use of those resources. • A discussion on the inter-linkages between HSDP, health financing strategy and the Health Insurance expansion and how they interact would be useful. • There is a need to provide a road map for resource generation and allocation based on clear and realistic assumptions. Alternatively, if optimistic assumptions are made, the document could list the ways to get there. • Various future health financing scenarios need to be considered in the light of certain new developments including the growth of the GDP, population, ageing, non-government funding mechanisms. • Scalable health financing experiments and other health financing means such as domestic philanthropic resources could be attracted and tracked so as to streamline them or scale them up for their wider and targeted use. • Household out-of-pocket spending is mentioned as a health financing challenge. But, the document does not provide

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	within a time span of five years. The HSDP seems to have followed an "arithmetic approach" compiling all the resource needs rather than a consolidation or "chemical approach" wherein different resource options and needs are well synthesized into a single plan for the sector. More analysis and clarifications are advisable. • Internal and external audits do not provide a full scope reasonable assurance on a timely manner, nor do they look at "value for Money" aspect. The systematic skipping of audit of every other financial year by SAV increases the fiduciary risk. The MOH, in consultation with others (SAV, MoF, DPs) should establish a workable audit framework which satisfies the need for reasonable assurance to all financiers. The document should elaborate on the audit framework.	any strategy to overcome the challenge. It will be useful if the document provides an action plan to minimize the household reliance on the out-of-pocket spending to finance health care. It could spell out how these resources could be channeled using the existing or to be developed pre-payment mechanisms
Dimension 4 IMPLEMENTATION AND MANAGEMENT Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy		
Attribute 13 : "Operational plans are regularly developed through a participatory process and detail strategic plan objectives will be achieved"		
Attributable characteristic 4.1 Roles and responsibilities of implementing partners are described for each strategy and intervention. 4.2 Each strategic objective has measurable annual milestones to assess progress towards implementation.	Roles and responsibilities of implementation partners are not clearly proposed in the Plan, it is hard to assess how ten key tasks would be successfully implemented. There are no clear milestones for each strategy/intervention presented.	
Attribute 14 : "Description of how resources will be deployed to achieve clearly defined outcomes" Attributable characteristics		
Attributable characteristic 4.3 The organization of service delivery is defined and identifies equitable allocation of resources (recurrent, investments) by level of care and roles and responsibilities of service providers; including plans for referrals and supervision. 4.4 Human resource (management and capacity) needs are identified, including staffing levels, skills mix, training, supervision and incentives. Gaps needed to implement the national strategy are identified and a plan	In the implementation section of the draft 3, it is not clear how financial/ human resources will be deployed to achieve clearly defined outcomes. It is assumed from, the experience in implementing the previous plan 2006-10, that the resource gap is not significant.	Should have a section to describe and discuss on resource deployment from national and international sources.

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
provided to solve identified gaps. 4.5 Current logistics, information and management system constraints are described, and credible actions are put in place to resolve constraints.		
Attribute 15: Procurement policy that complies with international guidelines and evidence of adequate, accountable, and transparent procurement and supply management systems with capacity to reach target populations.	Work in progresses	
Attribute 16 : "Specification of governance, management and coordination mechanisms for implementation"	Governance management and coordination are not clearly defined in the Plan; there is no specific reference to who are hold responsible for each of the specific objectives, central versus the provincial, district and commune levels. In other words, the accountability arrangement is non-existent under draft 3.	
Dimension 5 RESULTS, MONITORING AND REVIEW Soundness of review and evaluation mechanisms and how their results are used		
Attribute 17 Plan for M&E that includes clearly described output and outcome/impact indicators, with related multi-year targets that can be used to measure progress and make performance based decision.	The M&E section of the Plan is very modest compared to other sections. Totally, there are 19 basic indicators which are categorized into input, process and outcome, Selected indicators are presented as follows: • Input indicators: proportion of bed/10 000 people; proportion of physician/pharmacist/10 000 people; proportion of CHC having a physician/nurse... • Process indicators: proportion of CHS meeting national benchmark standards; coverage of health insurance... • Outcome/impact indicators: infant mortality rate; population growth rate; maternal mortality rate; prevalence of HIV; life expectancy at birth. All indicators are divided into multi-year targets for the whole period to measure progress and performance. The indicators were developed based on i) the Party's documents, Government's strategies or national plans; ii) annually targeting indicators designated by the National Assembly; iii) the MDG indicators; iv) achievements of the 2006-2010 period; v) orientations for the development of socioeconomics for the 2010-2020 period proposed in the draft document of the National Party Congress XI (Official of DPF); and vi) references from other	The current set of indicators and targets should be expanded to capture whole process (from input to impact) as much as possible and incorporate the left-out areas. More specifically, as suggested by the HPG, "the set of indicators could be strengthened by being made more specific and tailored to national needs and stratified (e.g. geographically) to incorporate inequity". HPG also suggested the following areas be better covered: equity, efficiency, safety, effectiveness, quality, compliance with diagnostic/service protocol indicators, pharmaceuticals, NCD, communicable diseases, injuries, newborn health, maternal and child nutrition, TB **(see more specific information in comments from HPG)**. In order to develop a good set of indicators that can summarize the M&E plan, it is important to develop a logical frame that describes clearly objectives and interventions selected, then input, process, output, outcome and impact indicators. The following include some of the indicators we suggest to be classified into the set of indicators: • Health status: Under five Malnutrition rate (height for age-stunning); • Effectiveness of curative and preventive measures: AIDS mortality rate per 100 000 population; TB incidence rate (AFB+) per 100 000 population;

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	developing countries with similar socioeconomic conditions. In order to develop health indicators, the DPF carried out several steps as follows: i) conducted an assessment of the achievement of health indicators in the previous Plan (2006-2010); ii) sent proposed indicators and multi-year targets measuring progress to all related departments and asked for comments; iii) consolidated all comments and feedback and sent the proposed indicators back to the related departments for second comment if they have; and iv) organized a meeting with MPI (Department of Labour and Social Affair and Department of Synthesizing) and National Assembly (the Committee for Social Affair), and then finalizing a set of health indicators (the document No 5597/BYT-KHTC, dated August 20, 2010). The proposed indicators are related to the following aspects: population; human resources; primary health care; health financing; preventive medicine; and maternal and child health. However, it is important to note that the proportion of indicators falling into population and human resources aspects account for more than 50% of total indicators. There was no indicators related to food safety, infectious and non-communicable diseases, quality of care; health information system; pharmaceutical industry; large investment programs (i.e. Decision 930) although they are considered key focuses. As a result, it is difficult, if not impossible, to measure progress and performance of prioritized actions listed in the plan using the proposed set of indicators. In-depth interview with an official at DPF revealed couple of reasons for selecting 19 indicators: “These indicators are most common and representative the potential impact. If we selected the indicators that are too specific, we may not able to collect them from all provinces. More importantly, these indicators can be monitored and evaluated easily. It is impossible for indicators to be selected if they are not evaluated or we do not have baseline information, i.e. qualitative indicators. To some extent, these indicators could be considered targets from which specific programs and its performance	Dengue fever incidence; average length of stay; proportion of detected hypertensive peopled get treated. • Quality of human resources: proportion of health workers with university and higher education; proportion of doctors licensed (required by the Law of examination and treatment). • Pharmaceutical industry: proportion of pharmaceutical manufacturers given GMP/GLP/GSP-WHO certificate; proportion of pharmacies given GPP certificate; • Health spending: proportion of state health expenditures spent on preventive medicine; out of pocket payment. More indicators could be found in NTP and other national strategies. A regular performance analysis should be officially in place. The JAHR process could be further developed, in order to serve the purpose of joint annual monitoring process (which would also have to draw from an internal monitoring process set up).

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	indicators such as proportion of people at risk using bed-net... would be developed and implemented." Other justifications supporting for not detailing the M&E is that "this five year plan should be seen as a guiding document from which specific programs will be developed with detailed indictors by in-charge Department or Institutions. Moreover, many indicators such as quality of care, financial management are not measurable". A JAHR team member thought that "it is important to emphasize that the 19 selected indicators serve the national five-year plan. They could not adequately reflect performance of the health sector. A full list of indictors for the five-year plan would be as large as ten folds." A regular performance analysis was not found in the Plan, but it's mentioned when interviewing health officials. The JAHR indicator recommendations, which were developed in a consultative process, do not appear to have been included in the Plan. Currently, JAHR is not an M&E of the Plan. "If JAHR was a tool for M&E of the Plan, it would have been done differently. Now, the two are different. Therefore, the plan should have a separate M&E section and indicators representing each activity, while JAHR still focuses on crucial issues of the health sector" (IDI with JAHR team member). Health official understands very well about the M&E and its indicators. They acknowledged that these selected indicators are not adequate and more should be added. However, they gave several reasons for not selecting all related indicators, for example "it could create a huge workload while we do not have time, human resource and finance".	
Attribute 18: Plan for M&E that includes sources of information for indicators and description of information flows.	The M&E section includes sources of information for each indicator, ranges from epidemiological data, routine HIS, Census and Vietnam Living Standard Survey. With respect to indicators collected by the MOH through the routine HIS, in 2009, the MOH issued a decision No 3440/QD-BYT promulgating a standardized health statistics reporting formats. These standardized data collection tools ensure that data collected is	For some indicator such as infant mortality rate and under 5 mortality rate, there are two sources of information including census and routine health information system. It is important to keep an eye on the results reported by these sources in case there are discrepancy between two sources. To serve as a good reference document for the M&E section, it would be very important to reconsider the role of JAHR. It would

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	logically linked to one-third of the selected M&E indicators at all levels and on a routine basis (3,6,9 months), although quality of this data is still debatable. (IDI with a statistician will be added) For M&E plan indicators that cannot be monitored from a routine basis such as infant mortality rate, life expectancy, maternal mortality rate, information from census will be applied. The M&E plan specified role of related organizations in collecting and reporting the selected indicators following the regulations on the national set of indicators. It also stated that the M&E framework proposed in the JAHR conducted by the MOH under support from Health Partnership Group will be used complimentarily for the M&E plan. There was no information gap reported, we found it adequate. However, this might be an issue if more indicators are added.	also be crucial to review the set of indicators developed for the JAHR to make sure that the adaptation into the five year plan is legitimate. This is also comments from HPG: "Though it is mentioned that the JAHR are used as a reference source to assess annual health sector performance, it is not stated that the JAHR will be used as a basis for jointly monitoring the implementation of the plan. It is essential, therefore, that the role of the JAHR be further clarified and redefined in the context of M&E of the Plan"
Attribute 19: Plan for M&E that includes descriptions of data collection/data management methods, tools and analytical processes (including quality assurance).	The M&E describes information source but not methods of data collection for each indicator. In fact, it assigned responsibilities to related organizations to collect data and reporting. It is assumed that these in-charge organizations will be responsible for managing and conducting data analysis. As there are several data sets such as routine HIS and census, data collection, management and analysis would vary and be out of reach of the MOH. The JANS team felt that data from national survey or census would be in good quality and that Quality Control is well in place, while information from the routine HIS collected from public facilities only, would be inadequate as private sector play an increasing role in service provisions. Comments from HPG revealed that: "Information currently reported can be unreliable and internally inconsistent. Denominators are inappropriate (e.g. coverage based on attendances not population); numerators are incorrect (e.g. not all infant deaths are fully counted); sources are inappropriate (e.g. hospital source for incidence/prevalence data); perverse incentives for over-reporting. There is no systematic data definition, collection, data processing, independent validation, reporting and use. The issue of independent validation is	Given that more indicators will be selected, details of roles and responsibilities of related stakeholders should be specified and stated in the five year plan.

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	particularly important. Even an official at the MOH admitted that "number of maternal deaths reported from public hospitals is not correct because a lot of patients were discharged before death, and died at home". Information from the routine HIS are collected quarterly from commune to district, district to province, and from provincial to central level--the MOH. As mentioned above about the decision No 3440/QD-BYT, there was a very detailed guideline on how health information is collected and reported from the commune level to central level. It should be noted that, "Quality of information collected from the routine HIS is not very good. However, it varies from one to another indicator. For example, it would be problematic with the indicator related to having at least check-ups during a pregnancy, because if the denominator includes only pregnant women consulting public health facilities, the true rate would be underestimated. " (IDI with a JAHR team member).	
Attribute 20: There is a plan for join periodic performance review (reporting of results against specific objectives and respective targets explaining any deviations) and processes for the development of related corrective measures.	The M&E section described how performance will be monitored over time. Specifically, National Assemble will carry out an M&E annually over the indicators designate to the health sector; the MOH will be responsible for M&E the overall performance of the health sector under support of the Health Partner Group through Joint Assessment of Health Report. Finally, provincial departments of health will be responsible for M&E the performance of the health sector within their province. Outputs of these activities are comprised of JAHR, M&E report of the National Assemble, and annual performance report of provincial department of health. Although the M&E did not mentioned about using of feedback on performance, we did find a two-way feedback mechanism in which information flows to central level and back to those providing them. For example, National Assembly will keep the MOH informed about their M&E activities on the indicators they assigned to the health sector. At provincial level, the M&E is implemented quarterly. "Currently (October) we are asking the organizations to report their performance within the first 9 months and submit the following	It is suggested that not all indictors are evaluated at the same time, for example, input and process indicators should be evaluated or monitored annually, while output indicators should be evaluated at least after 2 year of the implementation of the Plan.

Five dimensions and 21 attributes	Comments on process and content of draft 3	Recommendations on draft 3
	year plan. All organizations have to provide justifications for changes in the plan in the following year." (IDI with an official of Hanoi DOH) A annually report is submitted by the Provincial Department of Health to the Provincial People Committee and sent a copy the MOH.	
Attribute 21 M&E plan describes processes by which monitoring results can influence decision making (including financial disbursement).	The M&E section did not describe how the outcome is formally incorporated into future reorientation of policy decisions. But officials at MOH and provincial department of health emphasized the importance of the annually performance assessment reports. "The budget and plan targets can be adjusted after 9 months implementation. If responsible agencies found that they could not meet the designated targets, they would propose for adjustments." (IDI with an official at provincial DOH) Usually, an annual performance assessment is conducted in September to report how the plan was carried, what indicators are achieved, which activity and budget would be added in the following year.	

Annex 4 Comments on the Plan by HPG members

Part I: Situation Analysis

1. How do you see the situation analysis of the current draft of 5yr health plan reflect a comprehensive and participatory analysis of health determinants and health outcomes trends within the context of the country?

General comments:

Participation: There has clearly been a great effort on the part of MOH to better integrate the JAHR and the five year plan (though the final draft of JAHR 2010 has not yet been made available, DPs can see the reflection of previous discussions and consultations). The plan has successfully identified a number of important issues to be covered in the next five years. The JAHR team who conducted the analysis invited participation by many stakeholders. Therefore, this analysis is more comprehensive and participatory than those conducted in previous plans.

Despite significant progress, we recommend stronger participation to be promoted by those stakeholders already involved, as well as the expansion of stakeholders involved in the process (e.g. Social Committee of the National Assembly, Consumer representatives, professional groups, private sector, education and other relevant sector, representatives from grass-roots prevention and examination and treatment).

Comprehensiveness: Analysis of indicators and determinants could be improved considerably, based on already existing studies and surveys in different areas of the sector. Understanding the actual cause behind those indicators and determinants is important and will be helpful in justifying planned interventions.

For example, what is the **cause of the slow-down in reducing the MMR or what is the cause of "large" disparities between regions**, in terms of health outcomes (i.e. IMR). Other examples include the analysis of population structure and imbalanced sex ratio at birth. What is the impact of the young labor force (i.e. not only the needs but also the contribution they could make to increased size of health insurance fund to strengthen risk-sharing principle)? What is the cause and impact of imbalance sex ration at birth?

In general, better **analysis on the cause of death** will be necessary in future. Though this may not be possible at this stage, due to the lack of adequate record system, it is important to highlight this as one of the problems, and present adequate solutions to tackle this issue.

2. Do you see that the priority problems and problem areas are clearly identified in the situation analysis of 5yr health plan? Do you think if they reflect adequately problems of the current health sector? If not, what problems would you like to add if permitted?

General comments

The **analysis on morbidity and mortality tends to be general**, without specificity of which group of populations who are suffering most or where the issues should be addressed or found most salient to target therefore it would be difficult to know where the programs/ interventions in this plan should be implemented (see further note below on equity).

We suggest **better acknowledgement of the lack of integration between different areas of the system** (especially NTPs), partly resulting from **financing flows** to different sub-sectors/NTPs. We also suggest better acknowledgement of the **lack of integration of vertical programs in the health system**. This lack of

integration is clearly demonstrated in the plan through separate reference in the plan to separate projects in specific areas.

It would be important for the situation analysis to **describe more clearly what problems are most pressing in terms of preventing unnecessary deaths and illness or need to be addressed most urgently to improve examination and treatment**; what are the highest causes of mortality and morbidity, etc.

Given there are a number of programs that have been implemented over the last five years and these programs are found to be implemented again in this plan without specificity of where or not they are truly effective.

We suggest more attention should be paid to **vulnerable populations** (girls and women, ethnic minorities, migrants, IDUs, sex workers, victims of violence, PLHIV, people living with disability). These vulnerable populations do not have the same level of access to health care services as the majority groups.

We suggest including **stronger evidence on the low quality of health services** at health facilities (including causes) both public and private.

Specific comments:

Below are some suggestions of key areas where the analysis could go further:

A. General

Health determinants: physical and social-economic factors as core health determinants could be better addressed. Note also that injuries and accidents should be considered as health outcomes, not determinants. Furthermore, the discussion on health determinants does not appropriately cover social determinants such as gender inequality, educational discrepancies between different ethnic groups, social-cultural norms and behaviors. These determinants influence the health status of men and women differently.

Sex Disaggregated Data and Gender Analysis: Overall, data used in this report is not disaggregated by sex, ethnicity, age, and region. This results in weak gender analysis in the report. Disaggregated data assists us to identify different health needs of and capacity to assess to health services by men and women, boys and girls. When available and possible, data should be disaggregated by sex, age, region, and ethnicity in order to identify inequalities and inequities. The national health monitoring and evaluation systems should institutionalize the use of disaggregated data in analysis and planning.

B. Health systems building blocks

Human resources for health: We suggest the analysis should consider in more detail why the quality of training is limited, and whether it is linked with unclear requirements for the quality of the trainee. Service quality standards will define quality requirements for health staff.

We suggest more detailed be provided in the plan on **where imbalances in the health workforce exist** and where the interventions/programs will be targeted to improve that.

Little has been mentioned to the required **continuing medical education** - how and what programs MOH will design over the next five years and implement to ensure that CME requirement will be implemented adequately in line with the requirement of LET and Circular 07 (MOH) so by 2014 the MOH will have training capacity to ensure that 300,000 health providers who can receive required CME hours.

We suggest including more explicit reference to the need to strengthen **pandemic preparedness**, including through training of HR.

Health financing: we suggest there should also be explicit reference to **areas where a significant proportion of financing comes from external sources (e.g. HIV, contraceptives).** It will be extremely important to consider, in the coming years, how interventions in these areas can be sustainable, as this source of funding is progressively reduced (this is also **linked to risk analysis**).

Health information system: We suggest the analysis could be considerably improved by carrying out a **stakeholder analysis**: who is using the data and why?

We also suggest the current analysis could go further, looking at limited availability/ use of **disaggregated data, limited availability of data in some key areas** (burden of STI is not known, data on maternal and neonatal mortality are limited, stillbirths are not recorded by the health information system, etc.).

The analysis should also reflect the **lack of timely national surveillance systems for many communicable diseases**, specifically in the section referring to areas where data is lacking.

Research and development: There is little mentioning on the research and application of medical science in improving the health care quality as well as in capacity building in policy formulation, governance in detail where they are identified as priority areas. Application of IT in health services has been little and not been adequately addressed in the plan.

Governance: we suggest the issues around inexistent/inappropriate regulatory framework should be better addressed. For example, the question around **drug regulation** needs to be better addressed.

We also suggest better addressing questions around weaknesses of the current legal framework, and the lack of resources for strengthening it. This issue was extensively discussed through JAHR 2010 workshops, and a strong recommendation from stakeholders was the need for better consultation at provincial level, as well as the need to carry out impact assessments more systematically.

Examination, treatment and rehabilitation:

We suggest more attention could be paid to the following areas:

- **Quality is referenced but not defined** and there is inadequate reference to service safety and effectiveness.
- The health care network and grass-roots health care are referenced but there is no systematic review of needs for comprehensive primary health care in different settings;
- There is also inadequate analysis of the **varying performance of facilities at different levels** (communes, districts, provinces and national levels);
- **Gaps in service delivery** including chronic care for the aged, rehabilitation services, palliative care, mental health, dental health, imaging and laboratory services, allied health could be better highlighted.
- **Defining inability to develop treatment guidelines as a workload problem could be complemented by two fundamental points**: First, **adoption of treatment guidelines is a core governance function but this function does not appear to have received sufficient attention within the MOH**. Second, there are many treatment guidelines in the literature which would be appropriate for Vietnam. We suggest the core problem is that the **MOH needs**

better mechanisms and processes for selecting, translating and promulgating available guidelines.

- Private sector is referenced in a number of different areas. However, we would suggest providing **more information on the current challenges faced by MOH due to the mushrooming of the private sector**, particularly in curative care

Pharmaceuticals: we suggest including evidence on per capita spending on pharmaceuticals from NHA 2008, and linkage to **lack of access to essential medicines**, particularly for more disadvantaged populations.

Laboratories: currently the system is fragmented and inefficient as a result. There are laboratories for preventive medicine, TB, HIV, as well as laboratories set up by Administration of Medical Services, but no overall network to link those.

C. Other areas

We suggest **further analysis on MDG5 and sexual reproductive health**, including reference to the lack of data availability for MMR across different regions.

Newborn health and survival. Under 5 child mortality declined in Viet Nam and current data indicate that neonatal mortality (within 28 days of life) represents more than 50% of U5 mortality. The MOH in the National Plan of Action for Child Survival 2009-2015 identifies the **need of strengthening newborn care services in order to further reduce child mortality**. However this issue is not reflected in the plan. The focus still in child death; it should have more analysis on neonatal death, which will lead to more focus of interventions to address issue of newborn death.

Child nutrition, in particular stunting in children is not well documented. The fact that the first 24 months of life are the time of highest vulnerability and at the same time represent a window of opportunity to implement effective interventions to reduce stunting is not mentioned. This instead should be highlighted as nutrition programs need to be re-directed to focus on early childhood. Note that some new directions should become available in the new National Nutrition Strategy, currently under development. Those directions should be in line with the health sector plan. This issue is also reflected in the **ALTERNATIVE INDICATOR proposed for malnutrition**.

Maternal nutrition, in particular the high prevalence of anemia in women of reproductive age and pregnant women and the fact that MOH policies to reduce anemia are not implemented, are all issue that should be mentioned.

The issue of **double burden of malnutrition** (under-nutrition /stunting and obesity) should be considered. Data from NIN show an increased proportion of children with obesity in urban areas particularly in Ho Chi Minh city, requiring appropriate strategies to contain it.

The burden of **non-communicable diseases is only partially described**: issue of cancers, is not well addressed. Cervical cancer and interventions to prevent and manage it should be mentioned. Note that the MOH is planning a national survey to asses the burden of RTI/STI.

Emerging infectious diseases affecting Vietnam, partly as a result of globalization: It is also suggested (to complement the analysis on globalization, etc.) to add one sentence on the risk from the rapid spread of **emerging infectious diseases including pandemics originating outside the country** (e.g. Pandemic (H1N1) 2009).

Disability may also require more in depth analysis. This issues may be linked with better management of neonatal conditions leading to disability (birth asphyxia, severe prematurity, congenital malformations, genetic disorders).

Vulnerable groups are not well defined: adolescents, migrant workers. These groups may have less access to free care. Evidence suggests that **migrant workers** are not able to register themselves and their families for the health insurance. These issues should be better addressed, and subsequently reflected in the interventions as appropriate.

HIV/TB linkages: we suggest better referencing the linkages between these two areas, which in turn will have significant implications for the key interventions selected.

Occupational health becomes more and more important while Vietnam tries to become an industrialized country by 2020. The irrational use of chemicals and pesticides by farmers (70% population of Vietnam) leads to many health problems. The workers in the handy craft villages are working without proper protections contribute to increasing number of work accidents in construction and production sectors. However, occupational health has not been mentioned properly in the 5yr plan. The data and information in paragraph 1.3.4 environmental health extracted from Vietnam health report 2006 is too old. The plan should use the updated data provided annually by MoH's Health Environment Management Agency. More over, Basic Occupation Health Services (BOHS) as recommended by WHO which are now piloted in 5 provinces in Vietnam should be extended to other provinces in Vietnam

Emerging an pandemic threats: the current draft does not refer to recent experience of public health emergencies related to new and emerging infectious diseases including zoonotic risks and pandemics, nor does it make reference to International Health Regulations 2005 (IHR 2005) or the bioregional Asia-Pacific Strategy on Emerging Pandemic Diseases (APSED). Experience of the past decade includes two diseases that emerged from Asia (avian influenza A (H5N1) and SARS) to become global health security threats. Both had measurable macro-economic and social impacts, brought Vietnam to the world's attention, and could potentially have had more serious potential impacts. The national and global risk of avian influenza still persists in Vietnam and a number of other countries.

Specifically, following the paragraphs on Dengue fever, Dangerous accute diarheal epidemic, Malaria, Tubercolosis and HIV Pandemic, it is suggested to add a paragraph on Emerging Infectious Diseases (EIDS) with reference to SARS, Influenza A(H5N1), Influenza A(H1N1) and the human-animal-environment interface. This paragraph could summarize actual morbidity/mortality as well as the impact on national socioeconomic development (% impact on GDP), as well as potential risks if a severe pandemic had developed. It would also be appropriate to refer to the zoonotic nature of these EIDS and the effective collaboration with the agriculture sector particularly in the case of Influenza A(H5N1).

Climate Change – the aspect of Impacts of flood due to climate change that can lead to water source pollution and eventually to water-born diseases could be mentioned as a specific example of the negative impact of natural disasters on human health.

Environmental Heath – currently development projects in all sectors lack an adequate process for Health Impact Assessment (HIA). This could lead to have negative consequences on health after those development projects are put into operation. In the next 5 years, Vietnam as other countries in the regions will have to face the consequences of rapid urban and industrial development projects. Therefore, HIA should be considered in the 5-year plan too.

Gender Based Violence: The report has not yet recognized gender-based violence and domestic violence as a public health issue. GBV, poor sexual reproductive health, and HIV/AIDS are inextricably linked. Therefore, GBV deserves more attention. Gender based violence is not only a gender and social issue, but also a public health issue. Challenges include: policy implementation, prevention, and access to services. Recommendations should include strengthening the capacity of the health and social service sector at all

levels to screen and provide treatment, counseling, and referrals for clients experiencing GBV.

High rate of abortion: Viet Nam has very high rates of abortion and it is sometimes used for family planning purposes as a way of controlling the number (and sex) of children. This has strong impacts on the physical, mental and emotional health of women, as well as economical impacts. It would be good to reflect this alarming situation and to provide recommendations for improvements and options in the family planning and reproductive health policies.

Prostitution: It is strongly recommended to use the world “sex work” instead of “prostitution”, and “sex workers” instead of “prostitutes.”

3. At which extent do you see the goals, objectives, planned strategies, interventions and expected outcomes of the 5yr health plan contribute to improving health outcomes and meeting national and global commitments (such as MDGs and WHA resolution on PHC)?

Though there is reference to the need to strengthen PHC and specific interventions within this in the plan, a **comprehensive vision of how PHC will be strengthened is lacking**. The plan does not address fundamental issues such as the separation of curative and preventive care and challenges associated with this, nor the fragmentation of services provided through different vertical programs.

Outcomes are not yet clearly defined, and the structure does not demonstrate clearly how interventions will contribute to meeting key objectives, and clear results that can be expected to be achieved over 5 years. Formulation remains too general.

As the situation analysis currently does not provide sufficient in-depth (causal) analysis in certain key areas (as described above), the real scale of the problem is often not considered in a systematic way. This, in turn, makes it difficult to assess whether comprehensive set of interventions may not have been proposed to achieve targets.

There is also **inadequate consideration of the interdependence of issues within problem sets or of solutions within and between objectives**, which will greatly undermine the extent to which chosen interventions can successfully lead to the achievement of set outcomes.

On the other hand, important needs have been raised in the situation analysis which are not reflected in the objectives and activities. Examples include ageing of the population and preparation for the effects of climate change.

In the the area of Governance, suggest more specific reference to the need to **strengthen the legal framework.**

Regarding the **private sector**, although it has been touched on however no specific or concrete programs/interventions that are stated in the plan harness private sector in health care (other than a relatively general statement on developing mechanisms to strengthen collaboration with the private sector)

4. How do you see feasibility, appropriateness, equitability, effectiveness and sustainability of planned interventions of the 5yr health plan?

Feasibility: Clear assignment of responsibility is not given in the plan. There is missing reference to other stakeholders in implementing specific interventions, including other Ministries, VSS, provincial authorities, etc (though they are referred to in a general manner). Without this, it is difficult to state the plan is feasible.

From a technical point of view, the current listing of interventions is not sufficient to guarantee the feasibility of the plan because concrete interventions on "how to do" are not clearly defined.

Appropriateness & effectiveness: Interventions presented appear to be appropriate (despite the need for a greater linkage between them). However, further analysis may be needed to determine which of the interventions are technically required (e.g. which factors inhibit further development); or the relative timing required to ensure the interventions can effectively support development.

Equitability: equity is referred to several times in the plan. Specific measures are presented to improve equity, such as incentives for health workers in remote/rural areas. However, the plan still lacks specific interventions to address equity issues, including in accessing essential medicines, essential package of care (depth of coverage with insurance), etc.

Sustainability: without formal assignment of responsibility for implementation or commitment of resources it is unlikely the interventions will be sustainable.

5. How do you see risk assessment of potential barriers to successful implementation described in the current draft of 5yr health plan? Which kind of risks should be added?

A sound risk analysis is presented. It could be complemented by a number of aspects:

- Some **internal barriers** to successful implementation may include: inadequate levels of ownership by leadership level of the MOH and by implementing agencies; lack of capacity to implement; lack of capacity to monitor and manage implementation and/or enforce compliance.

  Other hindering factors may include **limited capacity**. It may be extremely useful if the five year health plan was accompanied by a TA plan, in order to support MOH achieve its set goals and objectives. This is perhaps something that MOH could consider after completion of the plan.

- External factors, such as **reduced ODA**. There is no reference to the funding implications of Vietnam reaching MIC status. This is particularly relevant, for example, in funding for HIV/AIDS and contraceptives which rely heavily on external financing. There is inadequate discussion of how to make interventions in this area sustainable, for example, through provision of deeper health insurance coverage, etc.

  In the discussion on risks related to market mechanisms and impact on equity, suggest including reference to commercialization of certain products (e.g breast milk substitutes in conflict with MOH policy of promotion of breastfeeding and stunting reduction strategy)

Part II: Process

1. Which individuals and/or organisations played a key role during the process of development of the 5yr health plan? Why did they play a key role? How were they involved?

HPG members are aware of early consultation with provinces. They are also aware that PDF sought to collect information from provinces and MOH departments to complete the plan. There were also early consultations with HPG members on drafts 1 and 2. However, the mechanism followed to incorporate provincial and departmental inputs, as well as

HPG comments into draft 3 and 4 is not clear. This is due in part to the fact that the preparation of draft 3 from draft 2 is not clear.

The involvement of stakeholders (other Ministries, mass organizations, etc) and their input into the current draft of the plan is not clear.

It would be useful, in the introductory section, for the process for developing the plan to be described, in order to serve as evidence that the document is a product of a wide consultative and participatory process.

DPs observe that through JAHR, broad consultation took place and there was extensive input from a range of stakeholders. There appears to be an issue around timing, however: the JAHR 2010 has not yet been made widely available. It is our understanding that the outputs from the JAHR should be available before planning (5 year and 1 year) begins.

Regarding the development of key tasks and M&E plan, it is not clear how provinces, other MOH departments and other ministries have been involved.

2. Do you think any other organisations and/or individuals should have been involved, but were not? If so, why were they not involved and how could their involvement have been enhanced?

There appears to be limited mention of the private sector and of professional organizations, which may indicate their inadequate involvement in the preparation of the plan.

Continued involvement of civil society and private sector stakeholders would be welcomed.

There is a concern that while the strategy for the development of people's health 2011-20 (2030) has received significant attention from higher levels of MOH (Department heads, as presented at HPG Q3), this has not been the case for the five year health plan.

3. Can you comment on the commitment and the ownership of relevant government organizations (MOH, MPI, MOF…) to 5yr health plan?

Different levels of engagement between the various departments within MOH and by the GVN ministries are not clear in the plan.

4. Support of all needed sectoral and multi-policies and legislation to allow successful implementation of 5yr health plan?

The Party, the National Assembly and the Government and Central Planning/Finance agencies have well documented policies which not only support but clearly mandate development of the Health Sector Plan. Moreover, these documents clearly specify needs and development priorities. The difficulty appears to have been adequate reflection of the range of policies into the plan, not just as a listing, but their linkage with specific interventions presented, and link with objectives to be achieved.

5. Any note in 5yr health plan on problems with implementing the needed regulatory framework and has a strategy to overcome enforcement problems

The regulatory framework for developing and implementing the plan is strong. Implementation issues may arise if ownership is not present (defined as active involvement/oversight of development and adoption in day-to-day management activities) of the 5 year plan by the MOH as a whole (as distinct from individuals who actively work to the plans creation).

Despite significant progress, there is also a concern that the involvement of Departments, National Targeted Programs and Provincial plans remains limited. The MOH organizational structure (departmental/NTP silos); administrative and managerial lines of authority and communication; overlaps/gaps in functional responsibilities appear to limit the scope for active participation from all key departments in the process.

6. Were there any meetings, discussions and/or agreements of relevant ministries and/or high-level (national assembly) on formal endorsement of 5yr health plan budget?

Though there may have been consultation and discussion with other sectors, the involvement of the latter in the implementation of the plan is not clear, and could be presented much more clearly.

The 5 year plan as a whole will be formally endorsed at Government level in due course. However, our understanding is that no official budget associated with the plan as a whole will be endorsed. Components of the plan (listed in section 5: some investment programs and projects) have formal endorsement from the Government. However, we are not aware of endorsement of budgets for a large proportion of activities proposed within the plan.

7. Were any kinds of evidence particularly useful or influential in the development of 5yr health plan? Why was this? Who produced it, why it was used and how was it used?

The WHO building blocks for development of the health sector are used as a basic framework. This provides a basis for systematic consideration of both service and enabling factors in the plan. Use of the framework is strongly supported. Further work is required for development of systematic constructs within the building blocks and for establishment of closer causal links between those building blocks. The current draft 3 of the plan, unfortunately, treats the building blocks as separate entities.

8. Do you think 5yr health plan strategies consistent with relevant higher (national development objectives) and/or lower level strategies (sub-national strategies and PHBs' strategies). Why? Examples?

In general, there is no clear evidence that the different strategies and plans are being developed as part of an integrated process, despite some similarities between the different documents.

It would be helpful for the plan to include a clear planning framework in its introductory section, and where the five year plan fits.

Link with SEDP (health component)

The five year plan and SEDP health component are organized around the same major areas, and the five year plan appears to provide more detail than SEDP in key areas. This is a very positive development. It would be helpful for further information on how priorities set for SEDP are reflected in five year plan, or how five year plan presents how these priorities will be implemented, etc.

Link with strategy for the people's health care and protection 2011-20 with vision to 2030

It is difficult to assess the degree of consistency, and this strategy has not been completed yet. It is surprising that the five year health plan appears to have been completed before the strategy; it is our understanding that the plan would present a way of "operationalizing" the higher level strategy, and therefore should be completely based on this strategy.

It is very encouraging to see that the set of indicators selected for the strategy is fully consistent with the list selected for the five year health plan.

It is also encouraging to see that the major areas of interventions are consistent with those of the five year health plan and SEDP health chapter.

Link with sub-national strategies

DPF, Line Departments, National Targeted Programs, and the Provinces each develop independent plans. These plans are alike in the formats specified by external agencies such as MPI or MOF. Though the NTPs and specific projects are referenced in the plan, it is not clear, however, how practical links are drawn between the plan which looks at the health system as a whole, and specific projects.

For example, it is not clear how the plan is linked with sub-national strategies such as HIV, nutrition, EPI, malaria, population and reproductive health, immunizations, etc. In a number of cases, the strategies for 2011-15 have not yet been made available by MOH, so it is difficult to answer the question fully. This entails that although key areas of the sector have been covered in the five year health plan, there appears to be inadequate reflection of programmatic priorities and corresponding objectives.

Other specific examples include:

At present, a National Environmental Health Action Plan (NEHAP) jointly developed by MoNRE and MoH was submitted to the government for approval shortly. Therefore, the 5-year plan should reflect the linkage with the NEHAP implementation. NEHAP was not mentioned at all in both status analysis and in the plan.

National Action Plan for Response to Health Impacts from Climate Change was already approved by MoH. Unfortunately, it was not mentioned in the 5-year plan of MoH. It's strongly recommended that the plan include that national action plan too.

We suggest stronger linkages between the Health Sector Plan and other sectoral plans such as Education.

There is also a concern that the plan developed by MOH to prepare and respond to emerging and pandemic threats is not adequately reflected in the plan.

Link with MTEF

The linkage with MTEF is not clear. It appears to be prepared as a separate process, including an independently derived set of planning priorities.

Link with JAHR

Despite stronger linkages, the issue of timing remains. This planning period the preparation of the JAHR and the development of the 5 year plan were concurrent activities when the JAHR is an essential input to the planning process

The JAHR indicator recommendations, which were developed in a consultative process, do not appear to have been included in the plan.

9. Do you see any similarities or differences between the development of 5yr health plan and the development of previous Plan and other national health policies? If so, what were they and why?

From the development partners' perspective, very positive steps have been taken by MOH in adopting a new approach to planning, which is more open, transparent, and

consultative. HPG members have had the opportunity to comment to the five year health plan at different stages, which they did not have before.

At the same time, partners have seen good progress made in terms of better integrating the JAHR and the five year health plan, and starting to use the JAHR as an integral part of the planning process. This has also led to a more systematic structure of the five year health plan into building blocks.

The efforts of MOH to involve provinces and MOH departments is also recognized, and represents a positive step forward.

It is also clear that MOH has taken the very first tentative steps towards development and ultimately using the 5 year plan as a management tool. Standard guidelines for Provincial Level Planning applying the national planning framework to sub-sector levels, is a major by-product of the current plan

Despite these positive developments, many challenges still remain, in particular:

- full involvement of provinces and seeing their inputs well reflected in the plan, particularly when looking at the framework for implementation (and corresponding budget)
- full involvement of other MOH departments and NTPs, and reflection in the plan of sub-sector strategies currently being developed. Though those strategies may not yet be completed and approved, it would be very helpful for the plan to draw on these, in order to ensure full consistency.
- Further expansion of consultation with appropriate time given for inputs to be provided from a broad range of stakeholders.

Part III: Finance and Auditing

- Is the 5-year plan accompanied by a sound expenditure framework with a costed plan?
- Does the 5-year plan 2011-2015 cover all the main sectoral/programme areas ?

All areas appear to be referenced at least, albeit with limited detail in some cases.

- Does the 5-year plan 2011-2015 provide cost details of systems support areas such as human resources, infrastructure, medicines and equipment and logistics ?

Due to the current structure of the expenditure framework, it is not clear how support areas such as HR are fully reflected. Although cost projections are made for different components of HR, it is difficult to see where **salary expenditures** are budgeted for, if at all. There are no HR projections included.
It is not always clear what strengthening the quality of human resources or health facilities entails, therefore it is difficult to determine whether the budget adequately reflects needs.
It is not possible to obtain a clear picture of capital investment in equipment and infrastructure, as it may be spread across different categories. At the same time, investments for different levels of care are not well disaggregated. It would be helpful, therefore, for this information to be presented in separate tables.

- Is the budget based on sectoral and/or programmatic guidelines ?

This does not appear to be the case. However, it is difficult to answer this question, as it is not clear which components are included under budget lines presented.

- Does the 5-year plan 2011-2015 provide details of budgets for decentralised structures where appropriate ?

It is not clear which proportion of the budget is to be allocated at central and provincial level. The annexes include budget per province for medical examination only.

- Does the budget use national budgeting and reporting templates and guidelines to enable integration with national accounts?

Not fully. While the annexes present disaggregated source of revenue, there does not appear to be a clear distinction of the following (as is presented in NHA):

-regional allocation
-expenditure on drugs

- Is there reasonable match between sector budgets and specific lines within central multi-year financial plans referring to health sector or multi-sectoral AIDS budgets?

It is not possible to answer this question fully, as draft strategies for key areas of the sector have not yet been made available.

For certain specific areas, such as EPI, it is not clear where the projected cost of vaccination programme has been incorporated (based on cYMP developed for GAVI). We would also be interested to see detailed costing for HIV/AIDS-related commodities, including ARVs, OI drugs, lab reagents, and methadone.

It would be useful, therefore, to prepare a different set of tables, where the financial information is "crossed" in a different way, better reflecting priority programmatic areas (such as EPI). Alternatively, it may be useful to provide more detail regarding where the costs of such programmes have been captured.

It is not clear where the budget for influenza and pandemic preparedness (prepared by GODP) is reflected. A total budget for 2011-2015 for these issues of $211 million was prepared (see annex). While a proportion of this may still be considered as emergency financing related to avian influenza, most of it now would need to be on a long-term and sustainable financing basis.

- Are ther different budget scenarios are provided for areas/sectors with high degree of unpredictability ?

The presentation of different scenarios is lacking. Assumptions used to make cost projections are not clear, and thus it is not possible to determine whether current projections are low, medium or high cost scenarios.

As there appears to be no clear distinction between what costs are necessary to maintain current levels of activity and costs to scale up services/improve quality, it is not possible to see what level of flexibility exists.

- Are revenue projections based upon explicit assumptions , include all sources of finance (local and external) and account for any foreseen uncertainties or risks ?
- Do calculations of revenue projections include any analysis of revenue by low/high or low/medium/high funding scenarios ?
- Are there processes for trying to gather data on possible revenue from different funding sources?

The annexes present a distinction between internal and external source of revenue.

On external revenue, the MOH is preparing a database for development partners support (milestone 1 of statement of intent), which seeks to capture information on future funding by development partners in key areas of the sector. It is strongly recommended that this information, when it becomes available, be incorporated into the projections.
On internal revenue, the annexes include a line on revenue from health insurance. It is not clear how the figures were derived, based on expected coverage.
There is no indication of potential cost savings/productivity gains that can be achieved through implementing a series of GoV policies, including revision of provider payment mechanisms, improved management of HR, etc.
In the projections, it would also be useful to demonstrate how, particularly in areas such as EPI and HIV which have been more dependent of external aid, the GoV will progressively cover the expenditure.

- Are there calculations of potential revenue for a multi-year period by source, with beginning and periods for each source of funding?
- Is revenue generated at provincial level reflected in overall revenue projections ?

Revenue from provinces are included in aggregated form.

Does the 5 year plan ensure health-financing systems that avoid catastrophic health care expenditure and impoverishment from result of seeking care?

Though health insurance law is referred to, it is important to consider a bigger picture of universal coverage of insured health services (i.e. the width (number of insured people), the depth (improved quality and benefit packages), and the height (risk protection / reduced out-of-pocket payment) of coverage). This is a political choice the country, like all other countries, has to make.

Furthermore, it is not clear how planned interventions in this area are reflected in the

cost projections. For example, under 5.05, there is reference to expanding health insurance coverage and social supports, however, it is not clear whether the amount budgeted covers the expansion of subsidies for health insurance only, or whether it should also include the cost of additional services (increased depth).
A similar question applies to 6.02 on adopting a list of minimum essential pharmaceuticals. It is not clear whether the total budget is for providing essential medicines free of charge for vulnerable groups?

- Are there policies and strategies that increase the amount of free services offered to poor and vulnerable families and individuals ?

Yes these are also reflected in annexes.

- Are there financial pooling strategies targeting poorer communities?

This aspect has not been addressed.

- Are costing and budget estimates for scaling up equitable services based on sound economic analysis?

There has been significant analysis carried out under MBB in a number of priority programs. However, it is not clear how this analysis has been reflected in the plan.
In general, it may be helpful for the plan to be accompanied by a detailed costing model, which would capture revenue (internal and external) as well as planned expenditure. This model could demonstrate clearly what assumptions are made and what targets cost projections are based on, and how varying assumptions/targets affect cost projections. Without such a tool, it is extremely difficult to understand clearly how cost estimates were arrived at, and how the MOH will adjust expenditure plans based on budget ceilings on an annual basis.
Such a model would also demonstrate more clearly links between results and expenditure.

- Is economic analysis and cost models for scaling up of priority programmes described in the 5-year plan?

No

- Is there analysis of costs to scaling up interventions at different speeds and implications on programme?

No

Part IV: Implementation and Management

1. Do you see roles and responsibilities of implementing partners are clearly described for each strategy and intervention in the current draft of 5yr health plan?

Roles and responsibilities for implementation do not appear to be described (at least not in the main document), and therefore it is hard to see how key tasks will be achieved. The current format alone may not adequately support systematic management of development of the health sector.

One major gap is the **lack of reference to VSS**, which is central to implementing health insurance law.

This issue appeared to have been address in former version of the plan, through the annex matrices that described more clearly roles and responsibilities. It is not clear from

the plan whether these matrices will still be used to provide more detail on implementation.

2. Do you see milestones to assess progress towards implementation in each strategic plan objective of the current draft of 5yr health plan are clearly identified?

A clear roadmap for implementation is lacking. There are no clear milestones presented.

3. Do you see how detail the description of how resources will be deployed to achieve clearly defined outcomes in the current draft of 5yr health plan?

There is a clear linkage between key areas of intervention and budget lines presented in the financial framework. There is clear presentation of funding available and funding source to be defined per health sector building block, and sub-components of building blocks.

However, as a number of outcomes are not currently clearly defined, it is not possible to say that the budget is clearly linked with outcomes. Sub-components remain to broad to establish clearly what the expected results will be from interventions. **It is not possible to see how the budget is linked to the achievement of clearly defined targets in each priority area.**

In some cases, it is not clear what the activity presented in the budget line entails in terms of outcomes, for example:

-ensure that public sector expenditure in the health sector and the target proportion of health expenditure allocated to preventive and primary care meets policy objectives (it would be helpful to include the specific policy objectives, and how much funding is necessary to achieve each one of them)

-control the capital works programme

-adopt a list of minimum essential pharmaceuticals, vaccine and medical consumables and ensure an adequate supply of these items is maintained in facilities at different levels (in this case, is the budget planned for the distribution of essential medicines to ALL facilities? If yes, the budget seems limited)

4. What do you think about the specification of governance, management and coordination machanisms for implementation of the 5yr health plan? Which issues need to be added?

Governance management and coordination of the 5 year plan are weakly defined; there is no specific reference to responsibility for specific objectives or activities within the objectives. In other words, the accountability arrangement is non-existent under this draft.

Part V: Results, monitoring and evaluation

1. How do you think the selected indicators reflect input, outcome and impact of the 5-year plan?

The selected set of indicators is comprehensive and reflects a mix of process and impact indicators.

However, as the plan and corresponding M&E framework are not clearly structured in terms of input, output and impact, it is not always clear how the selected indicators reflect these. It would be helpful to link indicators to objectives and interventions within those more clearly.

Selected indicators are not yet adequately disaggregated and do not yet adequately reflect variations (geographically; socially; minority groups etc).

2. What indicator would you like to add if permitted?

- The current set of indicators should be expanded/disaggregated in order to better reflect **inequity and/or inequalities**.
- In the area of pharmaceuticals, an indicator should be included on **availability of essential medicines**
- **Fatality rate at health facility**
- There is **focus on health sector indicators only**, and other aspects such as traffic **accidents (injuries and deaths), or food poisoning, smoking are not well reflected**. Even if the MOH is not directly involved in prevention (e.g. traffic accidents), they have a responsibility for providing emergency medical transport and trying to reduce deaths, and they also have a responsibility to advocate for stronger measures based on evidence of the number of cases being treated, the types of cases, etc. Responsibility should be taken by MOH to push stronger measures, etc.
- **Even if some indicators are not exact, they can still be used**. For example, individual adult smoking rates is the ideal measure of the problem, but we don't have that data. Instead we have a close proxy which is **% of households with a smoker**. As long as we define the indicator consistently across time we can still monitor the situation.
- There are also indicators that measure progress in implementing mechanisms, such as **% of hospitals reporting adverse events**. This is a valid measure of **hospital governance of patient safety**. If the hospitals are not even monitoring it, how can they hope to reduce it? The data are available annually, and we should include this.
- In the area of **human resources there is a great focus on doctors, pharmacists and nurses**. The health system needs also **technicians**. We proposed an indicator of the % of hospitals with 4 or more technicians (lab or imaging). Data is readily available.
- Patient Satisfaction Indicators;
- Communicable diseases (a number of which should be relatively easy to include such as incidence of dengue, measles, hepatitis B, malaria and rabies
- HIV/AIDS prevalence is of limited use as an indicator; we suggest a plan to collect data for HIV incidence.
- Mechanism to ensure quality of health services
- Mechanism to ensure quality of health information system to improve the health system

3. How do you think the M&E plan should be implemented?

- Roles and responsibilities of MOH and INGOs, and provincial department of health?
- How were they assigned?
- How regularly should periodic reviews be performed?

    1. For activities and inputs Annually
    2. For Health Sector Outcomes at most every 2-3 years

It may be useful to consider annual review of the plan through JAHR, and carry out a mid-term evaluation.

MOH should take leadership in implementing M&E plan and ensure wide consultation with stakeholders. This is already done through JAHR, to an extent.

However, there may be need for additional consultation for JAHR, including with provincial level.

- How JAHR reports should be taken into account for the M&E plan?

The JAHR process could be further developed, in order to serve the purpose of joint annual monitoring process (which would also have to draw from an internal monitoring process set up).

4. How do you think of validity and reliability of the information sources (MOH's reports, Health statistic year book, General Statistic Office) used for the M&E plan?

Information currently reported can be unreliable and internally inconsistent. Denominators are inappropriate (e.g. coverage based on attendances not population); numerators are incorrect (e.g. not all infant deaths counted); sources are inappropriate (e.g. hospital source for incidence/prevalence data); perverse incentives for misreporting. There is no systematic data definition, collection, processing, independent validation, reporting/usage process. The issue of independent validation is particularly important.

5. How important for the results of the M&E plan would be incorporated into the implementation of the 5-year plan in the remaining years?

M&E indicators of the plan should in the best scenario be used as the basis for dialogue on sector performance.

6. How do you evaluate the M&E plan?

Strengths

- There is reference to M&E in the plan

Weaknesses

- Responsibilities too general
- Some targets not appropriate
- Some Key indicators missing (see 7 above)

Though there is mention of the JAHR being used as a *reference source* to assess annual health sector performance, it is not stated that the JAHR will be used as a basis for jointly monitoring the implementation of the plan. It is essential, therefore, that the role of the JAHR be further clarified.

7. What could be done to improve the M&E plan?

Capacity building?

It is not so much a matter of capacity building but MOH initiative and commitment to dialogue on M&E conclusions and recommendations.

Finance?

Support for activities suggested under c.

Mechanism to ensure the use of M&E?

- Establish a TWG on Planning with a sub-group specializing in M&E
  Distribute, review/revise and implement HPG report on M&E
- Provide regular, validated management reports to Executive based on M&E

Collaboration between stakeholders?

- Continue/strengthen current HPG/WHO coordination activities.

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